Hull University Teaching Hospitals NHS Trust

Trust Board Meeting Held In Public

Tuesday 12 January 2021
10.00 am – 12.00 pm

Held via video conference
Appointment details issued by Rebecca Thompson, Corporate Affairs Manager

*Items marked * are for information only and will not be discussed unless agreed with the Chairman at the start of the meeting.*

Agenda

1	**Apologies and welcome**	verbal	Terry Moran - Chair
2	**Declarations of Interest**	verbal	Terry Moran - Chair
	2.1 Changes to Directors' interests since the last meeting		
	2.2 To consider any conflicts of interest arising from this agenda	verbal	Terry Moran - Chair
3	**Minutes of the previous meeting**		
	3.1 Minutes of the meeting held 8 December 2020	attached	Terry Moran – Chair
	3.2 Board Reporting Framework	attached	Rebecca Thompson – Corporate Affairs Manager
	3.3 Board Development Framework	attached	
4	**Matters Arising**		
	4.1 Action Tracker	attached	Rebecca Thompson – Corporate Affairs Manager
	4.2 Any other matters arising	verbal	Terry Moran – Chair
5	**Patient Story**	presentation	Makani Purva – Chief Medical Officer
6	**Standing Orders and Governance**		
	6.1 CEO Report and Covid Update	attached/verbal	Chris Long – Chief Executive
	6.2 Board Assurance Framework	attached	Rebecca Thompson – Corporate Affairs Manager
7	**Our Patient Impacts**		
	7.1 Performance Summary	attached	Ellen Ryabov – Interim Chief Operating Officer
	7.2 Quality Governance Summary	attached	Beverley Geary – Chief Nurse
	7.2.1 Ockenden Report – Compliance Update	attached	Beverley Geary – Chief Nurse
	7.2.2 Minutes and Summary from the Quality Committee	attached	Julie Bolus – Chair of Quality Committee

	7.3 Covid-19 Preparedness and Planning	attached	Michelle Kemp – Director of Strategy and Planning
8	**Our People Impacts**		
	8.1 Staff Overview	attached	Simon Nearney – Director of Workforce and OD
9	**Our Finance Impacts**		
	9.1 Finance Summary	attached	Lee Bond – Chief Financial Officer
	9.2 Pathology Services Business Case – Joint Collaboration Hull and York	attached	Lee Bond – Chief Financial Officer
10	**Board Reports**		
	10.1 Guardian of Safe Working Hours*	attached	Makani Purva – Chief Medical Officer
	10.2 Learning from Deaths – Mortality/Morbidity	attached	Makani Purva – Chief Medical Officer
	10.3 Maternity Incentive Scheme: CNST	attached	Beverley Geary – Chief Nurse
	10.3.1 PMRT Report	attached	Beverley Geary – Chief Nurse
	10.3.2 Birthrate Plus Update	attached	Beverley Geary – Chief Nurse
	10.4 Benchmark Report – MBRRACE Perinatal Mortality Surveillance Tool Standards	attached	Beverley Geary – Chief Nurse
11	Questions from the public relating to today's agenda	verbal	Terry Moran – Chair
12	Chairman's Summary of the Meeting	verbal	Terry Moran – Chair
13	Any Other Business	verbal	Terry Moran – Chair
14	**Date and time of the next meeting:** Tuesday 9 February 2021 10am – 12pm via Webex		

Attendance 2020/21

Name	14/4	12/5	18/6	14/7	8/9	10/11	8/12	12/1	9/3	Total
T Moran	✓	✓	✓	✓	✓	✓	✓			7/7
S Hall	✓	✓	Apols	✓	✓	✓	✓			6/7
T Christmas	✓	✓	✓	✓	✓	✓	✓			7/7
M Veysey	Apols	✓	✓	✓	✓	✓	-			5/6
T Curry	✓	✓	✓	✓	✓	✓	✓			7/7
U MacLeod	Apols	Apols	✓	✓	Apols	✓	Apols			3/7
M Robson	✓	✓	✓	✓	✓	✓	✓			7/7
L Jackson	✓	✓	✓	✓	✓	✓	✓			7/7
C Long	✓	✓	✓	✓	✓	✓	✓			7/7
L Bond	✓	✓	✓	✓	✓	✓	Apols			6/7
T Cope	✓	✓	✓	✓	✓	✓	-			6/6
M Purva	✓	✓	✓	✓	✓	✓	✓			7/7
B Geary	✓	✓	✓	✓	✓	✓	✓			7/7
J Myers	✓	✓	✓	✓	✓	✓	Apols			6/7
S Nearney	✓	✓	Apols	✓	✓	✓	✓			6/7
C Ramsay	✓	✓	✓	✓	Apols	-	-			4/5
E Ryabov	-	-	-	-	-	-	✓			1/1
J Bolus	-	-	-	-	-	-	✓			1/1

Hull University Teaching Hospitals NHS Trust
Minutes of the Trust Board
Held on 8th December 2020

Present:	Mr T Moran CB	Chairman
	Mr S Hall	Vice Chair
	Mrs T Christmas	Non-Executive Director
	Mr M Robson	Non-Executive Director
	Mr T Curry	Non-Executive Director
	Mrs J Bolus	Non-Executive Director
	Mrs L Jackson	Associate Non-Executive Director
	Mr C Long	Chief Executive Officer
	Mrs B Geary	Chief Nurse
	Dr M Purva	Chief Medical Officer
	Ms E Ryabov	Interim Chief Operating Officer
In Attendance:	Mr S Nearney	Director of Workforce and OD
	Mr S Evans	Deputy Director of Finance
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No **Item** **Action**

1 Apologies:

Apologies were received from Mr L Bond, Chief Financial Officer, Mrs J Myers, Director of Strategy and Planning and Prof U Macleod, Non-Executive Director

Mr Moran reported that it would have been Ms Myers' last meeting and he offered his sincere thanks on behalf of the Board for the work she had done relating to strategy and emergency planning. He added that her work relating to Covid had been outstanding. He wished her well in her new secondment position.

Mr Moran welcomed Mrs Julie Bolus, Non-Executive Director to the Board. Mrs Bolus had started on 1st December and would be the new Chair of the Quality Committee. He believed her experience and clinical background would be of great value to the Trust.

Mr Moran also welcomed back Mrs Ellen Ryabov as the Interim Chief Operating Officer and was delighted to have such an experienced person at this critical time.

Mr Moran thanked all colleagues and staff across the Trust for their continued commitment and hard work. He also asked the Board and visitors to observe a minutes silence for Nicola Diles, who worked in the Dietetics Team and John Gosnold who had retired from the Trust. Mr Moran added that there had been close to 400 deaths in the Trust since the pandemic began.

A minutes silence was observed

2 Declarations of Interest

2.1 Changes to Directors' interests since the last meeting

There were no declarations made.

2.2 To consider any conflicts of interest arising from this agenda
There were no declarations made.

3 Minutes of the previous meeting held on 10 November 2020
Item 6.1 Performance Summary – paragraph 3 – Mrs Ryabov advised that ED Performance was at 77.5% for type 1 and 86.2% for type 1 and 2 combined.

Item 8.1 Finance Summary – paragraph 3 – Mr Evans advised that the annual leave accrual was a valuation only and would not necessarily be paid.

Following these corrections the minutes were approved as an accurate record of the meeting.

4 Matters Arising
4.1 Action Tracker
The Board Development Framework would be presented to the February 2021 meeting following review of the current governance arrangements.

Mrs Bolus advised that Serious Incidents relating to Covid-19 would be reviewed at the next Quality Committee.

4.2 Any Other Matters Arising
There were no other matters arising.

5 Patient Story
Dr Purva introduced the item which was a video of mothers speaking about their experience of being pregnant during Covid-19 and had experienced the change in visiting arrangements for antenatal and birth appointments. The mothers in the video had not been allowed to have their partners with them and they all spoke of their experiences, worries and disappointment regarding this.

Dr Purva advised that all of the people in the video had given their consent for it to be shown and were aware that it would be made publically available.

Mrs Geary mentioned that changes to visiting and care and subsequently changed to so that these issues were not the experience now.

Mr Moran asked about visitors and end of life patients and Mrs Geary advised that end of life patients are allowed to have visitors and special arrangements were made in each case. Mrs Ryabov added that children were also allowed one visitor.

6 Standing Orders and Governance
6.1 CEO Report and Covid Update
Mr Long presented his report and highlighted the sad losses of Nicola Diles and John Gosnold.

Mr Long updated the Board regarding the Covid-19 situation and advised that rescheduling activity following the delays of cancer and other treatments was very unsettling on staff and patients and would take years to

recover properly.

The Trust had given the highest rate of flu vaccinations to staff in the Yorkshire region.

Mr Long reported that a new Executive Friday Forum had been introduced following the success of the Team Brief being held via Webex. A high number of staff had attended and it was the intention to carry on communicating with staff in this format.

Mrs Bolus asked about the rationalisation behind the planning of lost appointments in services. Mr Long advised that there were recovery plans available and these would be shared with Mrs Bolus.

There were currently 143 confirmed Covid-19 cases in the hospital which was a reduction from the peak but the decline was gradual. Mr Long advised that the numbers were coming down in line with the national rates, but he was concerned about the inevitable peak after Christmas into the New Year. He added that he was also concerned about the next peak happening during expected added winter pressures.

There had been a total of 398 deaths and 157 of them had been since 1st November. Mr Long was mindful of how this was impacting staff. Staff absence was reducing due to the fast testing available. There were no issues around the supply of PPE.

Mrs Geary advised that the Trust, although not mentioned in the press would begin vaccinating on 9th December 2020. The vaccination hub was based at the Castle Hill site and the Trust would be inviting patients that were over 80 from care homes. The Trust would also be offering vaccinations with outpatient appointments for the over 80 year olds first. A daily report would be completed relating to the number of vaccinations given and the Board would be updated monthly.

Mr Moran spoke of the hope that the vaccination brought to people after a very difficult year.

Mr Hall asked if there were reserves in place should people not turn up for their vaccine and Mrs Geary advised that the roll out was very prescriptive and there would be no wastage which meant that if there was a risk a dose may be wasted because of a patient failing to turn up then it would be offered to a member of frontline staff so that it was not wasted.

Mr Long commended Mrs Geary and the team for their difficult work in an ever changing environment to get the programme up and running, he also thanked the Communications team for their input in managing the tightly controlled media. Board colleagues added their thanks.

Resolved:
The Board received and accepted the report.

6.2 Board Assurance Framework
Mr Moran presented the report and advised that the year-end targets were becoming more ambitious due to the Covid-19 situation. Mrs Thompson added that the report had been updated since the last meeting and the

Quarter 3 risk ratings would be presented at the January 2021 Board meeting.

Resolved:
The Board received and accepted the report.

7 Our Patient Impacts

7.1 Performance Summary

Mrs Ryabov presented the report which highlighted the Covid-19 impact on performance and the phase 3 plan that was being implemented. The elective performance was 74% against a plan of 83% and the Trust was working with health partners to review the challenges and ensure as much activity was undertaken as possible.
Outpatients had been undertaking video and telephone conversations but consultants were now risk assessing patients coming into the Trust for face to face appointments. Using technology was still the preferred option to reduce the amount of people at the hospital.

The Trust continues to report zero 12 hour Trolley waits.

There was a deterioration of the Cancer 62 day performance for September due to sustained increased referrals into the service seen since July 2020 and capacity constraints, particularly in the breast pathway and endoscopy. The Faster Diagnostic Standard continues to be achieved.

There was general deterioration across a number of Unplanned Care Indicators during October. ED performance for October 2020 was 79.7% (combined), a 4.5% reduction on performance for September 2020.

There were 171 occasions during the month where ambulance handover exceeded 60 minutes. This equates to 4.8% of all conveyances, which is deterioration from the 1% of conveyances with a handover time exceeding 60 minutes seen in September. Flow throughout the Emergency Department has been compromised throughout October as the department responded to increasing numbers of suspected and confirmed Covid-19 admissions and increased length of time in the ED waiting for Covid-19 results before patients can be placed in the appropriate environment and pathway within the hospital.

Mrs Ryabov advised that it was important to consider the significant levels of priority 2 patients and how theatre capacity and daycase work could be expanded to tackle the numbers.

Mrs Ryabov reported that the GIRFT team had undertaken a review of the Emergency Department and had commended the team, environment and processes despite the current Covid-19 pressures.

Mr Moran asked for the GIRFT team report to be circulated to Board members. **ER**

Resolved:
The Board received and accepted the update.

7.2 Quality Governance Summary

Mrs Geary presented the report advised that a daily safety huddle is held

with all senior matrons, PDM`s and Nurse Directors, in order to provide a forum for the delivery of any key messages and the identification of any issues that require escalation through the Trusts Command Structure. In addition the Senior Nursing Team hold a team brief three times a week for all ward sisters/charge nurses to deliver key messages with regards to the Trusts Surge plan, staff redeployment and any issues pertaining to Covid-19 , particularly in relation to staff training and any quality issues/concerns.

The above processes have been implemented to provide assurance to the Senior Nursing Team with regards to the quality of care specifically relating to Covid19. This is further supported by the introduction of a robust `Ward to Board` communication strategy, to ensure all key messages are delivered across all nursing teams within the Trust.
Mrs Geary advised that there had been another Covid-19 outbreak in November to the 9th Floor. The details of this outbreak will be presented to the Quality Committee in December 2020.

Falls although still within control limits had increased as had falls with harm. A detailed paper had been shared with the Executives and the Quality Committee would review the issues.

The Trust had received funding for winter volunteers who would act as way-finders pointing patients and relatives in the right direction as well as offering hand gel and face masks to all visitors to the hospital.

Mr Long spoke of Mr Raymond Dove who had been a willing volunteer for many years at the Trust and had sadly lost his life to Covid-19 recently. He added that Mr Dove had done a huge amount of work for the Trust and had been a member of the patient council.

Mrs Geary advised that the Trust was meeting regularly with the CQC and was responding to risks relating to Covid-19, patient flow and nurse staffing in particular. She added that the Infection Prevention and Control BAF had been updated and would be presented to the Quality Committee in December 2020.

Mrs Jackson asked about the outbreak on H90 and whether patients or staff were showing symptoms. Mrs Geary advised that the 3 asymptomatic people were staff.

Mr Hall asked about frequent fallers and the increase in falls and whether key staff involved had been lost due to the Covid-19 vaccination roll out, leaving others over-stretched. Mrs Geary advised that the Clinical Nurse Specialist for Falls worked part time and had increased her hours to work on the vaccination programme.

Resolved:
The Board received and accepted the report.

7.2.1 Minutes and Summary from the Quality Committee
The Board received the minutes and summary from the Quality Committee. Mrs Bolus thanked Prof Martin Veysey as November was his last meeting as Chair.

7.3 Covid-19 Preparedness and Planning
Mrs Ryabov presented the report on behalf of Ms Myers and highlighted the Phase 3 recovery plan in place. She also highlighted the capital plans around updating the

Mrs Ryabov also highlighted the Acute and Medical Elderly Unit and that the first 2 phases of the work are on track to be complete by the 2nd week of December. This will enable the AMU to move back down to the ground floor and increase the Medicine bed base by 8 beds, thereby completing the provision of additional beds for Winter as per the Trust Winter Plan.

Resolved:
The Board received and accepted the report.

7.4 Minutes and Summary from the Ethics Committee
The minutes were received by the Board.

8 Our People Impacts
8.1 Staff Overview
Mr Nearney presented the report and advised that staff absence had reduced to 8.7% which included maternity leave. Normal staff absence was usually 3.6%.

Staff testing had commenced and 2500 staff and families had been tested so far. The Trust had received 7000 lateral flow tests and 6000 had been distributed so far. Mr Nearney advised that OCS cleaning staff had been asked for their personal details so that testing kits could be allocated but OCS had refused to release it. Mr Nearney advised that a meeting between the Trust and OCS was being held to discuss this further.

Staff vacancies were at 3% which was a healthy position but Care Hours Per Patient Day had reduced to 7.52 due to services being stood up as part of the recovery planning.

Mr Nearney commended the teams on the flu vaccination campaign and reported that it had started early due to the switch of resources required for the Covid vaccination.

Mr Nearney reported that the Trust had seen a 38% uptake for its National Staff Survey completions. York was at 35%, NLAG 34% and Harrogate 31%.

The Trust has received funding to implement Schwartz Round in their virtual shorter format called “Team Time” and the “Big Blue Button” educational classes had been implemented.

Mrs Bolus asked about Statutory and Mandatory training and how it looked due to the pandemic. Mr Nearney advised that the Trust was at 83% and this was mainly due to the on-line courses offered but would ensure that the latest data was circulated to the Board. **SN**

Mr Robson asked if there had been any non-clinical outbreaks and Mr Long advised that there had been a cluster of cases had occurred in the Estates Team. Mrs Ryabov added that there had also been a cluster on Suite 36 which housed discharge liaison, social workers and ED staff.

Mr Hall asked about staff welfare and asked if they could check in and out with someone before and after shifts. Mr Nearney advised that this process was in place should staff want to use it.

Resolved:
The Board received and accepted the report.

9 Our Finance Impacts

Mr Evans presented the Financial Summary and advised that the first month of the second half of the year had gone slightly better than plan and that Covid-19 expenditure had been low compared to previous months.
The Trust reported a break-even position for the first 6 months with 'true-up' income of £10.6m. Final confirmation of £6.6m of this income is still awaited.

For the second six months the Trust submitted a planned deficit of £6.0m based on shortfalls on other income (eg Car parking, catering, private patients) and the expected need to account for an annual leave provision at year end due to the potential difficulty of staff being unable to take all their leave in year due to Covid-19 pressures. The Trust has had no official feedback on the plan submitted.

Mr Evans advised that the winter ward had opened early and this would increase costs but added that there were no major financial pressures and the Trust was still aiming to achieve its financial plan.

Mr Evans highlighted the medical incentive scheme and how Trusts could be penalised for their reductions in activity. He advised that the Trust was waiting for confirmation that the scheme had been suspended due to the pandemic.

Mr Evans also advised that any expenditure to the Independent Sector when assisting with the recovery should be funded by the Centre and an update would be received at the next Board meeting in January 2021.

Mrs Christmas asked about the capital programme and how the Trust was going to achieve the £59m by the year end as this was very ambitious. Mr Evans advised that it was very challenging but tenders were being managed. The capital programme would be reviewed at the end of month 9 and would be reviewed in line with the ICS and money could be moved around if necessary. At the current time the plan was still on track to be delivered.

Mr Robson asked about further Covid-19 surges and whether there was a risk that this would cause cost pressures for the rest of the year. Mr Evans advised that he was expecting the Covid-19 spend to increase.

Resolved:
The Board received and accepted the report.

10 Questions from the public relating to today's agenda

There were no questions raised by staff or members of the public.

11 Chairman's Summary of the Meeting

Mr Moran stated that it was rare that something impacts on everything we

touch such as work and home life and since the pandemic, this year had been hard for everyone. Given that Christmas would soon be upon us, he added that whatever people's faith and beliefs were he hoped they could enjoy some time at Christmas and hoped that next year would bring new hope with the new vaccines.

12 Any Other Business

There was no other business was discussed.

13 Date and time of the next meeting:

Tuesday 12 January 2021, 10am – 12pm, via Webex

Trust Board Annual Cycle of Business 2020 – 2021 - 2022			2020							2021							2022						
Focus	**Item**	**Frequency**	**Apr**	**May**	**Jun**	**Jun Ex**	**July**	**Sept**	**Nov**	**Jan**	**Mar**	**May**	**May Ex**	**Jul**	**Sept**	**Nov**	**Jan**	**Mar**	**May**	**May Ex**	**Jul**	**Sept**	**Nov**
Opening Items	Declarations of Interest	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Minutes of the last meeting	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Action Tracker	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Board Reporting Framework 2020-2021-2022	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Board Development Framework 2017-2021	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Chair's Opening Remarks	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Chief Executive Briefing	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Patient Story	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Staff Experience (Frontline staff team in attendance)	Every Meeting	x	x	x				x	x	x	x		x	x	x	x	x	x		x	x	x
	Board Assurance Framework	Quarterly		x			x		x	x		x		x		x	x		x		x		x
Our Patient Impacts	Performance Report	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Quality Report	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Covid-19 Recovery Report	Every Meeting		x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Minutes and Escalation from the Performance and Finance Committee	Every Meeting					x																
	Escalation from Ethical Clinical Policy Prioritisation Committee	As required	x				x																
	Minutes and Escalation from the Quality Committee	Every Meeting					x																
Our People Impacts	Staff Overview Report (Including Nurse Staffing)	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Minutes and Escalation from the Workforce, Education and Culture Committee	Every Meeting					x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
Our Finance Impacts	Finance Report (including Statement of Comprehensive Income)	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
Items for Approval	Freedom to Speak Up Guardian	Quarterly					x		x			x		x		x	x		x		x		x
	Guardian of Safe Working Hours	Quarterly					x		x	x		x		x		x	x		x		x		x
	Quality Accounts	Annually						x	x			x							x				
	Statement of elimination of mixed sex accommodation	Annually				x							x							x			
	Annual Accounts	Annually				x							x							x			
	Going Concern Review	Annually				x							x							x			
	Audit Letter	Annually				x							x							x			
	Annual Report	Annually				x							x							x			
	Workforce Race Equality Standards	Annually						x				x							x				
	Workforce Disability Equality Standards	Annually						x				x							x				
	Modern Slavery	Annually						x				x							x				
	Emergency Preparedness Statement of Assurance	Annually						x							x							x	
	NHS Resolution Maternity Incentive Scheme	Six-Monthly						x		x				x			x				x		
	Business Cases	As required					x																
	Self-Certification and Statement	Annually			x							x							x				
Reports to the Board	Nursing and Midwifery Report (included in Staff Overview Report)	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Fundamental Standards	Six-Monthly						x			x				x			x				x	
	National Patient Survey	Annually							x							x							x
	National Staff Survey	Annually									x							x					
	Gender Pay Gap	Annually									x							x					
	Digital Exemplar	Annually							x							x							x
	Scan for Safety	Annually							x							x							x
	Fit and Proper Person Report	Annually					x					x							x				
Strategy and Planning	Operating Framework	As required						x		x							x						
	5 Year Plan	Annually								x							x						
	Trust Strategy Refresh	As required																					
	Operational Planning	Annually								x	x						x	x					
	Financial Planning	Annually			x						x	x						x	x				
	Capital Planning	Annually			x						x	x						x	x				
	Winter Planning	Annually							x								x						x
	Equality, Diversity and Inclusion Strategy	Every 3 Years									x												
	Assurance against Equalities Objectives	Annually						x							x							x	
	People Strategy	Every 3 Years																	x				
	IM&T Strategy	Every 3 Years										x											
	Research and Innovation Strategy	Every 3 Years									x												
	Trust Strategy Implementation Update	Every 6 Months							x		x				x			x				x	
	Estates Strategy inc. Sustainability and backlog maintenance	Annually			x						x	x						x	x				
Governance	Standing Orders	As required	x	x			x	x															
	Safeguarding Annual Reports	Annually						x						x							x		
	Learning from Deaths Report/Mortality and Morbidity	Quarterly		x	x				x	x		x		x		x	x		x		x		x
	Information Governance Update	Six-Monthly				x				x			x				x			x			
	Health and Safety Annual Report	Annually						x						x							x		
	Director of Infection Prevention and Control Annual Report	Annually						x						x							x		
	Quality Improvement Programme	Six-Monthly			x							x					x		x				
	Responsible Officer Report	Annually						x							x							x	
	Seven Day Working Assurance Framework	Six-Monthly							x		x				x			x				x	
	Preparation for EU Exit	As required			x			x	x														
	Developing Workforce Safeguards	Six-Monthly						x			x				x			x				x	
	Review of Director's Interests (Inc Fit and Proper Persons)	Annually					x					x							x				
	Cultural Transformation	Six-Montly						x			x				x			x				x	
	Board Calendar of Meetings	As required						x										x					
	Review of Board Effectiveness	Annually						x							x							x	

Hull University Teaching Hospitals NHS Trust
Board Development Programme 2020-21
Overarching aims:
• The Board to be focussed on the Vision, Values and Goals of the Trust in all that it does
• To provide strategic direction and leadership for the Trust to be rated as 'outstanding' by 2021-22

Board Development Dates 2021	Strategy Refresh	Honest, caring and accountable culture	Valued, skilled and sufficient workforce	High quality care	Great Clinical Sevices	Great specialist services (until March 19)	Partnership and integrated services	Research and Innovation (from March 19)	Financial Sustainability
09-Feb-21			Reforming of the NHS - How we can actively shape what the new world looks like.		**Area 4 BAF 4**: There is a risk that the Trust does not meet contractual performance requirements for ED, RTT, diagnostic and 62-day cancer waiting times in 19-20 with an associated risk of poor patient experience and impact on other areas of performance, such as follow-up backlog				**Area 4 BAF 7:1**: There is a risk that the Trust does not achieve its financial plan for 2019-20
13-Apr-21				**Area 4 BAF 3:** There is a risk that the Trust is not able to make progress in continuously improving the quality of patient care and reach its long-term aim of an 'outstanding' rating			**Area 4 BAF 5**: That the Humber, Coast and Vale Health and Care Integrated Care System is not able to collectively make progress on developing and delivering integration due to Covid-19 recovery; momentum on work previously in progress could be lost		
08-Jun-21	Strategic drivers/balanced scorecare review		**Area 2 BAF 2**: The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust					**Area 4 BAF6**: There is a risk that the Trust does not develop and deliver ambitious research and innovation goals and secure good national rankings in key areas.	
10-Aug-21		**Area 1 BAF 1:** Board Leadership and Strategy Development							**Area 2 BAF 7.3**: Estates/Tower Block update

12-Oct-21					**Area 4 BAF 4**: There is a risk that the Trust does not meet contractual performance requirements for ED, RTT, diagnostic and 62-day cancer waiting times in 20-21 with an associated risk of poor patient experience and impact on other areas of performance, such as follow-up backlog				
14-Dec-21				**Area 4 BAF 3:** There is a risk that the Trust is not able to make progress in continuously improving the quality of patient care and reach its long-term aim of an 'outstanding' rating					**Area 4 BAF 7:1**: There is a risk that the Trust does not achieve its financial plan for 2020/21

plan and capital requirements

Other topics to consider:
Board leadership and cultural development
Workforce data reporting
Strategic drivers/factors Deep Dive
IT Strategy/roadmap and cyber security
Estates/Tower Block update
Research, innovation, partnerships
Commercial strategy
Efficiencies and Productivity
HSJ Patient Safety Awards/ Trust award nominations and profile

Strategy Refresh	Honest, caring and accountable culture	Valued, skilled and sufficient workforce	High quality care	Great clinical services	Partnership and Integrated Services	Research and Innovation	Financial Sustainability

	BAF1 : There is a risk that staff engagement does not continue to improve The Trust has set a target to increase its engagement score to above the national average and be an employer of choice There is a risk that the Trust's ambition for improvement and for continuous learning is not credible to staff, to want to go on a journey to outstanding with the organisation What could prevent the Trust from achieving this goal? Risk that staff do not continue to support the Trust's open and honest reporting culture Failure to act on new issues and themes from the quarterly staff barometer survey would risk achievement Risk that some staff continue not to engage	BAF 2: The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust Work on medical engagement and leadership fails to increase staff engagement and satisfaction Lack of affordable five-year plan for 'sufficient' and 'skilled' staff What could prevent the Trust from achieving this goal? Failure to put robust and creative solutions in place to meet each specific need. Failure to analyse available data on turnover, exit interviews, etc, to inform retention plans	BAF 3: Principal risk: There Is a risk that the Trust is not able to make progress in continuously improving the quality of patient care and reach its long-term aim of an 'outstanding' rating What could prevent the Trust from achieving this goal? That the Trust does not develop its learning culture That the Trust does not set out clear expectations on patient safety and quality improvement Lack of progress against Quality Improvement Plan That Quality Improvement Plan is not designed around moving to good and outstanding That the Trust is too insular to know what outstanding looks like That the Trust does not increase its public, patient and stakeholder engagement, detailed in a strategy	BAF 4: There is a risk that the Trust does not meet contractual performance requirements for ED, RTT, diagnostic and 62-day cancer waiting times in 19-20 with an associated risk of poor patient experience and impact on other areas of performance, such as follow-up backlog What could prevent the Trust from achieving this goal? ED performance did improve following a period of intensive support and improvement focus but performance requires a Recovery and Improvement Plan to meet contractual requirements In all waiting time areas, diagnostic capacity is a specific limiting factor of being able to reduce waiting times, reduce backlogs and maintain sustainable list sizes; this is compounded by staffing and capital issues A focus on 62-day cancer targets has brought about improvements and a continued focus is required to	BAF 5: Principal risk: That the Humber, Coast and Vale STP does not develop and deliver credible and effective plans to improve the health and care for its population within the resources available and that the Trust is not able to influence this. In particular, that the lack of a mature partnership both at local 'place' and across the STP will hamper the quality of care and services the Trust is able to provide, as it will slow progress in the development of integrated services and access to transformation funds. What could prevent the Trust from achieving this goal? The Trust being enabled, and taking the opportunities to lead as a system partner in the STP The effectiveness of STP delivery, of which the Trust is one part	BAF 6:Principal risk: There is a risk that the Trust does not develop and deliver ambitious research and innovation goals and secure good national rankings in key areas. What could prevent the Trust from achieving this goal? Scale of ambition vs. deliverability Current research capacity and capability may be a rate-limiting factor Increased competition for research funding What could prevent the Trust from achieving this goal? The Trust being enabled, and taking the opportunities to lead as a system partner in the STP	BAF 7.1: There is a risk that the Trust does not achieve its financial plan for 2019-20 What could prevent the Trust from achieving this goal? Planning and achieving an acceptable amount of CRES Failure by Health Groups and corporate services to work within their budgets and increase the risk to the Trust's underlying deficit BAF 7.2 Principal risk: There is a risk that the Trust does not plan or make progress against addressing its underlying financial position over the next 3 years, including this year What could prevent the Trust from achieving this goal? Lack of achievement of sufficient recurrent CRES Failure by Health Groups and corporate services to work within their budgets
	Risk that some staff do not acknowledge their role in valuing their colleagues Risk that some staff or putting patient safety first						Failure to put in place 2-3 credible year plan to address the underlying deficit position BAF 7.3 Principal risk: There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability What could prevent the Trust from achieving this goal? Lack of sufficient capital and revenue funds for investment to match growth, wear and tear, to support service reconfiguration, to replace equipment; capital funding is not available against the Trust's critical priority areas but is available in others, making the capital position look more manageable than operational reality

Principles for the Board Development Framework 2017 onwards

Key framework areas for development *(The Healthy NHS Board 2013, NHS Leadership Academy)* looks at both the roles and building blocks for a healthy board.
With the blue segment highlight the core roles and the crimson segments defining the building blocks of high-performing Trust Boards.

Overarching aim:

- The Board to be focussed on the Vision, Values and Goals of the Trust in all that it does
- To provide strategic direction and leadership for the Trust to be rated as 'outstanding' by 2021-22

Area 1 – High Performing Board

- Do we understand what a high performing board looks like?
- Is there a clear alignment and a shared view on the Trust Board's common purpose?
- Is there an understanding the impact the Trust Board has on the success of the organisation?
- Do we use the skills and strengths we bring in service of the Trust's purpose?
- How can we stop any deterioration in our conversations and ensure we continually improve them?
- How can we build further resilience, trust and honesty into our relationships?
- Does the Trust Board understand the trajectory that it is on and the journey needed to move from its current position to an outstanding-rated Trust?
- What is required in Trust Board leadership to contribute to an 'outstanding'-rated Trust?

Our recent cultural survey (Barrett Values) gave us a clear blueprint of the culture that our staff desire. This is also embedded within our Trust Values and Staff Charter defining the behaviours we expect from everyone in order to have a culture that delivers outstanding patient care

- Is this reflected at Trust Board level? Do Trust Board members act as consistent role-models for these values and behaviours?
- What else is needed at Trust Board level in respect of behaviours? Towards each other? To other staff in the organisation?

Area 2 – Strategy Development

Strategy refresh commenced

- Outcome: for the Trust Board to have shared understanding and ownership of the Trust's strategy and supporting strategic plans, and oversee delivery of these, to be rated 'outstanding' by 2021-22
- What is the role of the Trust in the communities it serves? What is the Trust Board's role in public engagement?
- How does the Trust Board discharge its public accountability?
- To link this to Area 4 (exceptions and knowledge development) as needed

Area 3 – Looking Outward/Board education

Providing opportunity for Board development using external visits and external speakers, to provide additional knowledge, openness to challenge and support for the Board's development and trajectory

- Outcome: to provide opportunities for Board knowledge development as well as opportunities for the Board to be constructively challenged and underlying working assumptions to be challenged
- To provide an external focus to the Board not just for development but also to address the inward-facing perception reported by the Board itself as well as by the CQC

Area 4 – Deep Dive and exceptions

Internal exceptions that require Board discussion and knowledge development and ownership of issues, as they relate to the Trust's vision and delivery of the strategic goals

- Outcome: Board to challenge internal exceptions
- Board to confirm its risk appetite against achievement of the strategic goals and the over-arching aim of becoming high-performing Trust Board and 'outstanding' rated organisation by 2021-22

Hull University Teaching Hospitals NHS Trust
Trust Board Action Tracking List (January 2021)

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
December 2020						
03.12	Board Development Framework	Updated Board Development Framework to be presented to the Board	TM/RT	January 2020		
COMPLETED						
01.12	Performance Report	GIRFT Visit to ED – Report to be circulated to the Board members	ER	December 2020		Completed
02.12	Staff Overview	Latest Statutory and Mandatory Training figures to be emailed to the Board members	SN	December 2020		Completed

Actions referred to other Committees

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT

Hull University Teaching Hospitals NHS Trust

Trust Board

12 January 2021

Title:	Chief Executive Report
Responsible Director:	Chief Executive – Chris Long
Author:	Chief Executive – Chris Long

Purpose:	Inform the Board of key news items during the previous month and excellent staff performance.	
BAF Risk:	N/A	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	
	High quality care	
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	
Key Summary of Issues:	Covid deaths, hospital hub vaccination, Oxford vaccine approval	

Recommendation:	That the board note significant news items for the Trust and media performance.

Hull University Teaching Hospitals NHS Trust

Chief Executive's Report

Trust Board 12 January 2021

1. Key messages from December 2020

Covid Deaths
We reached a very sad point in our history last week when we recorded 500 deaths since the start of the pandemic.

Each of these people will never be just a number to us or the staff who looked after them. They are someone's parent or grandparent, sibling or friend and we extend our heartfelt sympathies to those mourning their loss.

It is vitally important that we continue to impress upon our hospital users and staff as well as the public that we can all play a part in helping to halt the spread of the virus to prevent more deaths. We are continuing to promote the Government's instruction to stay at home, only leave your house if it is essential and, if you need to go out, wear your mask in public areas, stay two metres away from each other and wash your hands regularly to help stop the spread of this virus.

Hospital Hub
We were very pleased and proud to be named as one of the first wave of hospital hubs to be administering the Pfizer vaccination to over 80s and care home staff.

On 9 December Sheila Page, 84, became the first person in Humber, Coast and Vale region to receive the Covid-19 vaccine. Sheila, who has seven grandchildren and eight great-children, was happy to speak to the media and told everyone who was there to witness this historic event that it was one of the best Christmas presents she'd ever had.

Priority groups have been determined by the Joint Committee of Vaccinations and Immunisation (JCVI) because they are at greatest risk from Covid-19. As more supplies of the vaccine have been received, we have extended our vaccination programme from Castle Hill to include our own staff and this is now well underway.

This has been a great effort by all involved in establishing a process and operating procedure for vaccinations and everyone involved must be congratulated for making this such a success.

Oxford Vaccine
The Trust was extremely proud to have played its part in the development of the Oxford Astra/Zeneca vaccine. Approval of the vaccine was granted on 30th December following extensive trials during 2019. A vaccine trials team at HUTH was rapidly assembled in May 2019 to help recruit participants and administer vaccinations to cohorts of participants over the course of several months.

This team of of consultants, nurses, admin, clinical trials assistants, phlebotomists and runners all came together with one common purpose to help deliver a vaccine for use as quickly as possible.

In a few short months they:

- screened 643 volunteers

- enrolled 494
- processed 3300 samples and sent them to Oxford
- delivered 755 vaccinations
- saw 36 symptomatic volunteers
- implemented 17 Substantial Amendments

This is an incredible achievement and the team should be rightly proud to have played their part in a piece of work which has global significance. Well done to everyone involved.

A&E After Dark
HUTH's hospital heroes returned to our screens on Monday 4th January with the second series of A&E After Dark. The Channel 5 docu-series, produced by Crackit Productions, first broadcast in June this year follows the night shift at Hull Royal Infirmary with a specific focus on the emergency department and staff working in urgent care. Series two was filmed over a two month period in the autumn of this year.

A&E After Dark once again accompanies Hull's team of dedicated doctors, nurses and other healthcare specialists as they respond to out-of-hours falls and fractures, assaults and overdoses, car accidents and cardiac arrests. What will be unique about this series is the insight it gives into caring for patients in the context of Covid-19, including the additional stresses and strains it not only places on health services but on the people working within them.

3. Media activity

There were a total of 75 articles and broadcasts relating to HUTH in December. The vast majority were related to Covid-19 and the vaccination roll-out. Of these:

- 37 positive (50%)
- 33 factual (44%)
- 4 negative (5%)
- 1 neutral (1%)

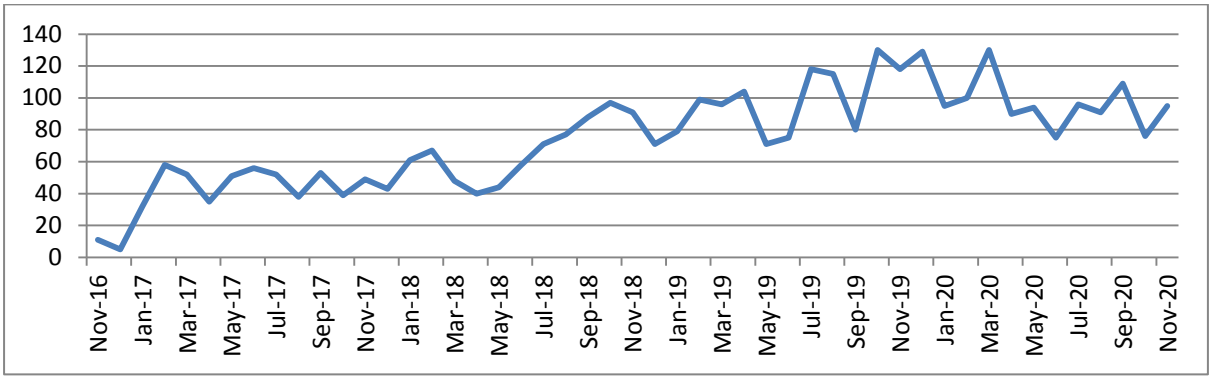
Social media
Facebook
Total "reach" for Facebook posts on all Trust pages in December – 320,656
Hull Women and Children's Hospital – 75,504
Castle Hill Hospital – 72,603
HEY Jobs page – 6,482
Hull Royal Infirmary – 65,055
Hull University Teaching Hospitals NHS Trust – 101,012

Twitter @HEYNHS
272,600 impressions in December 2020
8656 followers
Tweets with highest number of impressions related to Covid vaccinations and staff receiving abuse

3. Moments of Magic
Moments of Magic nominations enable staff and patients to post examples of great care and compassion as well as the efforts of individuals and teams which go above and beyond the call of duty. They illustrate our values at work and remind us that our workforce is made up from thousands of Remarkable People.

Please visit the intranet to read the most recent nominations.

Number of Moments of Magic submitted by month Nov 2016 - Nov 2020:



Hull University Teaching Hospitals NHS Trust

Trust Board

January 2020

Title:	Board Assurance Framework 2020-21
Responsible Director:	
Author:	Rebecca Thompson – Corporate Affairs Manager

Purpose:	The purpose of this report is to present the Board Assurance Framework to the Trust Board for review and to discuss any gaps in assurance or positive assurance that may have an impact on the current risk ratings.	
BAF Risk:	N/A	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great clinical services	✓
	Partnership and integrated services	✓
	Research and Innovation	✓
	Financial sustainability	✓
Summary of Key Issues:	Each year, the Trust Board determines the key risks against the achievement of the Trust's strategic objectives. The Board Assurance Framework for 2020-21 is set in the context of the Covid-19 pandemic; in strategy terms, the way that the pandemic has affected business as usual will affect the progress that the Trust will be able to make towards its strategic objectives this year but this will not be the totality of what affects the Trust's ability to make progress on its strategic objectives. The Trust Board approved the Board Assurance Framework at its meeting in July 2020.	

Recommendation:	The Board is asked to review the BAF, to be aware of the assurance and control needs identified, to inform current and future discussions of these areas for this financial year. The Board is also asked to review the proposed Q3 ratings for approval.

Hull University Teaching Hospitals NHS Trust

Board Assurance Framework

1. Purpose of this report

The purpose of this report is to present the Board Assurance Framework to the Board for review and to discuss any gaps in assurance or positive assurance that may impact the current risk ratings.

2. Background

The Trust Board is responsible for setting its assurance framework, to capture the key risks to achieving the Trust's strategic goals, and detail the level, or lack, of assurance during the year as to what extent the level of risk is being managed. The Board Assurance Framework (BAF) also determines what an acceptable level of risk would be. The BAF is a key governance mechanism to measure and monitor the level of strategic risk in the organisation.

The Trust has put in place a 'ward to board' process for risk management, for the BAF to include reference to relevant risks form the Corporate Risk Register, which is reviewed and agreed by the Executive Management Committee. This provides the opportunity to link corporate-level risks where they impact on the strategy and achievement of the Trust's over-arching goals.

Page 1 of the Board Assurance Framework consists of a visual to group the strategic risks in to 5 domains. This can help as an aide-memoire as to where a discussion 'fits' in terms of strategic discussion. The BAF can be populated through discussions framed around risks and assurance to the strategic objectives.

The Board's approach to the BAF was reviewed by the internal auditors in 2019-20 and gave an opinion of 'substantial assurance', the highest level of assurance, for the way in which the BAF was constructed and used by the Board and its Committees. There was one recommendation to further develop the BAF, which was to put timescales on any identified gaps in controls for resolution. This has been built in to the attached BAF for 2020-21.

3. Quarter 3 Board Assurance Framework

As part of the process for signing off the third quarter Board Assurance Framework, each of the strategic objectives have been considered.

The following section provided a summary of the discussions and sources of assurance relating to each strategic objective.

BAF 1 Honest Caring and Accountable Culture

Principal Risk: There is a risk the Trust does not make progress towards further improving a positive working culture this year.
The BAME network is now established with events in the diary.
There are capacity issues due to staff absences which were increasing due to Covid-19.
Overall the Trust vacancy position is 3%, recruitment and retention remains a key priority.

Risk rating at the start of the year = 12
Q1 risk rating = 12
Q2 risk rating = 12
Q3 proposed risk rating = 12
Year-end target risk rating = 4

BAF 2 Valued, Skilled and Sufficient Staff
Principal Risk: The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust

Lack of affordable five-year plan for 'sufficient' and 'skilled' staff to meet demand
There are risks around staff availability and staff absence due to Covid-19.

Health and wellbeing programme to be piloted and evaluated in December 20, Great Leaders management support clinics introduced and the Trust has also received funding to implement Schwartz Round in their virtual shorter format called "Team Time".

Risk rating at the start of the year = 12
Q1 risk rating = 12
Q2 risk rating = 12
Q3 proposed risk rating = 12
Year end target risk rating = 4

BAF 3 High Quality Care
Principal Risk: There is a risk that the Trust is not able to make progress in continuously improving the quality of patient care and reach its long-term aim of an 'outstanding' rating

The Quality Committee received an update from the Plastics Service and this had highlighted a substantial increase in referrals which was compounded by capacity issues. ENT would be the next service to attend the Quality Committee for review.

Covid Fundamental Standard audits had been introduced and were showing positive results.

There have been 0 Trust apportioned MRSA bacteraemia between 1st April and 30th October 2020.

During October 2020 there were 0 Never Events and 8 Serious Incidents declared.

Risk rating at the start of the year = 16
Q1 risk rating = 16
Q2 risk rating = 16
Q3 proposed risk rating = 16
Year-end target risk rating = 8

BAF 4 Great Clinical Services
Principal Risk: There is a risk to access to Trust services due to the impact of Covid-19
1- There has been a deterioration in the Trust's performance on a number of key standards as a result of the organisation responding to Covid-19
2- There is a level of uncertainty regarding the scale and pace of recovery that is possible and the impact of national guidance
3- Planning guidance being released in stages across the year

Due to the rise in Covid-19 cases a number of elective cases had been cancelled. Recovery planning was ongoing.

ED performance had deteriorated due to swabbing patients and general flow through the hospital.

ENT, Cardiology, Ophthalmology and Plastics specialities were being reviewed as they had the largest waiting lists and backlogs. Ophthalmology and Plastics had both presented to the Quality Committee regarding patient harm.

Cancer performance and 52 week waits have been impacted by the second wave of Covid-19.

During the latter part of October, the Trust saw a rapid increase in the number of covid admissions to hospital and subsequently surpassed the peak number of admissions that it saw during the first surge.

Consequently this led to significant pressures across the urgent and emergency pathway and a reduction of the planned care programme to enable the conversion of elective wards to covid wards and mobilisation of the Covid surge staffing redeployment plan.

Risk rating at the start of the year = 20
Q1 risk rating = 20
Q2 risk rating = 20
Q3 proposed risk rating = 20
Year-end target risk rating = 8

BAF 5 Partnership and Integrated Services
Principal Risk: That the Humber, Coast and Vale Health and Care Integrated Care System is not able to collectively make progress on developing and delivering integration due to Covid-19 recovery; momentum on work previously in progress could be lost

The Trust is working closely with local partners to identify joint working arrangements. HUTH/NLAG are reviewing service models to improve services across the Humber region. There are further developments regarding Frailty pathways, Community Paediatrics and the Outpatient Transformation programme.

HUTH is the Covid vaccination hub for the Humber Coast and Vale area and has successfully commenced the vaccination programme.

Risk rating at the start of the year = 9
Q1 risk rating = 9
Q2 risk rating = 9
Q3 proposed risk rating = 9
Year-end target risk rating = 3

BAF 6 Research and Innovation
Principal Risk: There is a risk that the Trust does not develop make progress in developing its research capability, capacity and partnerships

HUTH has managed a successful portfolio of Covid 19 studies that provide access to potentially life preserving or life-extending treatment not otherwise available to the patient can continue with appropriate safeguards. This achievement has been formally recognised by the Clinical Director of the Yorkshire and Humber CRN.

HUTH represents the Hull City Region Vaccine Hub and is one of 6 hubs in Yorkshire and Humber. To date HUTH has received £116,000 dedicated Vaccine Task Force funding to support the delivery of covid-19 vaccine trials.

HUTH will continue to provide equitable access for patients and staff to both Urgent Public Health Research and non-COVID-19 research where it is possible and safe to do so.

The Quality Committee discussed reducing the risk rating due to the work that has been carried out, but it was agreed that a further review in March 2021 would give a fuller picture of research work against the targets.

Risk rating at the start of the year = 12
Q1 risk rating = 12
Q2 risk rating = 12
Q3 proposed risk rating = 12
Year-end target risk rating = 6

BAF 7.1 Financial Sustainability
Principal Risk: There is a risk that the Trust does not achieve its financial plan for 2020-21

The Trust reported a break-even position for the first 6 months with ‘true-up’ income of £10.6m.

For the second half of the year the Trust has submitted a plan deficit of £6m based on shortfalls on other income (eg Car parking, catering, private patients) and the expected need to account for an annual leave provision at year end due to the potential difficulty of staff being take to take all their in year due to Covid19.

At month 7 the Trust has reported an in-month deficit of £0.52m, which is £0.18m better than the submitted plan of £0.7m deficit. The improvement was driven by reduced expenditure on general supplies and services. Most other budgets were close to plan.

Risk rating at the start of the year = 12
Q1 risk rating = 12
Q2 risk rating = 12
Q3 proposed risk rating = 12
Year-end risk rating = 8

BAF 7.2 Underlying Financial Position
Principal Risk: There is a risk that the Trust does not plan or make progress against addressing its underlying financial position over the next 3 years, including this year (year 2)

NHS Finance details future performance being measured at a system (ICS) Level. As this is an evolving picture it is unclear how this will impact on the Trust's underlying position.

Risk rating at start of the year = 16
Q1 risk rating = 16
Q2 risk rating = 16
Q3 proposed risk rating = 16
Year-end risk rating = 4

BAF 7.3 Capital Planning
Principal Risk: There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability

The reported capital position at month 7 shows gross capital expenditure of £14.6m. The main areas of expenditure relate to Capital COVID (£2.6m), Backlog maintenance (£1.5m); Expansion of Acute bed base (£2.2m) and Robotic Scheme (£1.5m).

The forecast position for capital expenditure is £59.6m and this includes assumptions on the Trust receiving PDC allocations for such items as backlog maintenance, ED Urgent and Emergency Care business case and critical infrastructure. To date the Finance Teams were confident that the allocations would be spent by 31 March 2021.

Risk rating at start of the year = 12
Q1 risk rating = 9
Q2 risk rating = 9
Proposed Q3 risk rating = 9
Year-end risk rating = 8

3.2 Corporate Risk Register
An element included in the BAF is the corporate risk register. The updated Corporate Risk Register is reviewed monthly by the Executive Management Committee at operational level. There are currently 16 risks on the corporate risk register.

BAF 1 staff culture = 0 corporate risks
BAF 2 sufficient staff = 8 corporate risks
BAF 3 quality of care = 2 corporate risks
BAF 4 performance = 3 corporate risks
BAF 5 partnership working = 0 corporate risks
BAF 6 research and innovation = 0 corporate risks

BAF 7.1 financial plan= 1 corporate risk
BAF 7.2 financial sustainability = 0 corporate risks
BAF 7.3 capital funding and infrastructure = 0 corporate risks

The 4 risks that do not map to a specific area on the BAF are the four Trust-wide risks relating to Emergency Planning and Preparedness.

The number of corporate risks relating to staff, quality of care and performance have remained static in the last 2 months so represent the key areas of 'burden' of risk identified for the organisation.

The corporate risk register contains one over-arching corporate risk about the Covid-19 pandemic, which was originally detailed in to 8 operational, Trust-wide risks underneath this. This is being regularly reviewed by the Covid-19 Command structure, and two risks recently closed and the risk ratings revised for a number of these underpinning risks. The Covid-19 corporate risk does not map to one singular BAF area and is an over-arching risk management situation for the whole Trust.

Mapping corporate risks helps to show the link between operational and strategic risk; if the number of corporate risks in a particular BAF area increases, it could indicate that strategic issues are starting to have an operational effect on patients and staff; like, the number of corporate risks in a BAF area suggests that there are already operational effects from a strategic issue and increases can be indicative of a risk escalating.

4. Recommendation

The Trust Board is asked to review the BAF, to be aware of the assurance and control needs identified, to inform current and future discussions of these areas for this financial year.

The Board is also asked to review the proposed Q3 ratings for approval.

Rebecca Thompson
Corporate Affairs Manager

January 2021

PEOPLE
Honest, caring and accountable culture
Valued, skilled and sufficient staff
Research and innovation

Strategic risks:
Staff do not come on the journey of improvement – measured in staff engagement and staff FFT scores

Work on medical engagement and leadership fails to increase staff engagement and satisfaction

Lack of affordable five-year plan for 'sufficient' and 'skilled' staff

Trust does not capitalise on opportunities brought by the name change and growing partnership with the University, missing opportunities for staff and patients

FINANCE
Financial sustainability

Strategic risks:
Failure to deliver annual financial plan and associated increase in regulatory attention

That the Trust is not able to formulate and implement a three-year financial recovery plan to leads to financial sustainability, and that this failure impacts negatively on patient care

PATIENTS
High quality care
Great clinical services

Strategic risks:
Failure to continuously improve quality
Failure to embed a safety culture
Failure to address waiting time standards and deliver required trajectories – increased risk of patient harm and poorer patient and staff experience

INFRASTRUCTURE
High quality care
Financial sustainability

Strategic risks:
Growing risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability

Lack of sufficient capital and revenue funds for investment to match growth, wear and tear, to support service reconfiguration, to replace equipment

Linked to three-year financial recovery plan – risk that capital requirements cannot be met and pose an increased risk to financial recovery

PARTNERS
Partnership and integrated services

Strategic risks:
Risks posed by changes in population base for services
Lack of pace in acute service/pathway reviews and agreement on partnership working
Risk of lack of credible and effective STP plans to improve services in the local area within the resources available, and a lack of influence by the Trust in these plans
STP rated in lowest quartile by regulator in initial ratings

BOARD ASSURANCE FRAMEWORK 2020-21 – Version updated 29 December 2020

GOAL 1 – HONEST, CARING AND ACCOUNTABLE CULTURE

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating (Imp x likelihood)	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (mitigate gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
1	Chief Executive	From the Trust's strategy: *One of our key priorities is the creation of a positive working culture, because we know that investing in our staff's development, and supporting and caring for them, will enable them to deliver great care; with commitment, compassion and courage.* *Principal Risk*: There is a risk the Trust does not make progress towards further improving a positive working culture this year *What could prevent the Trust from achieving this goal?* Risk that Covid-19 impacts on staff morale, or staff energy to be on a journey of improvement when working in the reality of a pandemic, +/- working in different teams or settings through redeployment Failure to act on	None	**4 (impact major) x 3 likelihood possible = 12**	Establishment of the Workforce, Education and Culture Committee to provide Board-level oversight and accountability for key elements of the People Strategy Refreshed People Strategy focusses on: leadership capacity and capability, empowering staff to lead improvement, equality, diversity and inclusion, employee engagement, communication and recognition Workforce Transformation Committee oversees delivery of the People Strategy, including staff engagement and cultural development; Workforce, Education and Culture Committee set up to seek assurance on progress being made Engagement of Unions via JNCC and LNC on staff survey and associated action plan Board Development Plan will include development of unitary board and leaders by example Leadership Development Programme commenced April 2017 to develop managers to	Action to address identified areas of poor behaviours, as determined by consistently low staff engagements scores in some areas – to be tasked to WECC and Workforce Transformation Committee for service plans to be agreed by close Q2 Consideration of a plan specifically for medical engagement – suggest timescale of end Q2 Need to undertake workforce engagement and transformation as part of Humber Acute Services Review – timescales per HASR progress	**12**	**12**	**12**		**4 major x 1 rare = 4**	**<u>Positive assurance</u>** Covid-19 has led to daily/regular communications and updates to all staff – level of staff communication has increased positively and can take lessons from this when returning more to business as usual Detailed papers to Trust Board on staffing picture including additional psychological support, access to additional support, risk assessments and support to BAME Leadership Network At the WEC Committee in August the 2020 Staff Survey results showed that the Trust is above average in the following themes: equality, diversity and inclusion, morale, safe environment – bullying & harassment, violence and safety culture. Trust vacancy position 3% excluding Covid. **<u>Further assurance required</u>** Timing and ability to be able to return to specific work on staff engagement, leadership development and other activities that have been impacted by Covid-19 and whether Q2 Is a realistic timescale for this Understanding impact on staff morale, impact of staff moves and redeployment on training and development and bringing organisation on journey of improvement during a sustained period of managing Covid-19 Understanding of impact on staff morale and engagement if/when central financial support for Covid-19 staff support is ended

		new issues and themes from the quarterly staff barometer survey would risk achievement Risk that some staff continue not to engage Risk that some staff do not acknowledge their role in valuing their colleagues			become leaders able to engage, develop and inspire staff – continued in 2019 with additional cohorts; 2020 virtual programme being developed, using learning from previous programmes Trust acknowledged by commissioners and regulator to be open and honest regarding patient safety and staffing numbers Regular reports to the Trust Board on the People Strategy Significant staff support put in place for Covid-19 including 24/7 psychological first aid support Daily/regular messages to staff on Covid-19 activity, Trust Surge plan, PPE, staff support, staff testing Board-level leadership in HASR and maintaining momentum on progress Covid-19 reflection piece – gain insights from staff on successes that should be maintained following Covid-19 surge activity					

Risk Appetite

The Trust has been managing and mitigating the level of risk posed by staff culture since 2014, and has been on a journey of improvement on staff engagement. There needs to be a renewed focus on staff culture to bring about a new level of improvement. The appetite for risk is high, insofar as the Trust has worked in a high-risk environment regarding staff culture, which has been mitigated over time as a result of acknowledging the poor staff culture in 2014 and putting a robust plan in place to engage with staff ever since. The Trust wants to mitigate this to a lower-level risk in respect of the impact that poor engagement and poor behaviours have; the Trust is not prepared to take risks with staff culture where this jeopardises patient care or staff welfare. Additional communications and staff welfare have been brought in during Covid-19, from which positive lessons can be taken, linked to this level of risk appetite – resolutions have been put in place quickly before risks in staff numbers or engagement occurred with Covid-19.

GOAL 2 – VALUED, SKILLED AND SUFFICIENT STAFF

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 2	Director of Workforce and Organisational Development Support from Chief Medical Officer and Chief Nurse	From the Trust's Strategy: *We will become the employer of choice locally and in the NHS regionally, with staff choosing to start and continue their careers with us. We will also increasingly attract staff to our posts from across the UK and wider world.* *Principal risk:* The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust Lack of affordable five-year plan for 'sufficient' and 'skilled' staff to meet demand *What could prevent the Trust from achieving this goal*? National and international shortages Impact of Brexit on availability of EU workers Costs of supporting overseas recruitment Impact on staff health and	F&WHG: anaesthetic cover for under-two's out of hours SHG: registered nurse vacancies Medicine HG: Risk that patient experience is compromised due to an Inability to recruit and retain sufficient nursing staff across the HG F&WHG – inability to access dietetic review of paediatric patients – staffing Medicine HG: multiple junior doctor vacancies F&WHG: Shortage of Breast pathologists F&WHG: Delays in Ophthalmology follow-up service due to capacity F&WHG	**4 (impact major)** **3 (likelihood possible)** **= 12**	Refreshed People Strategy articulates changing workforce requirements Workforce Transformation Committee and WECC assurance – staying ahead to meet changing workforce requirements, international recruitment and the introduction of new roles (such as Nurse Associate, qualified ACP posts etc) Remarkable People, Extraordinary Place campaign – targeted recruitment to specific staff groups/roles Review of international recruitment needs for 2020-21 Golden Hearts – annual awards and monthly Moments of Magic – valued staff Health Group Workforce Plans in place and held to account at monthly performance management meetings on progress to attract and recruit suitable staff and reduce agency spend Improvement in environment and training to junior doctors so that the Trust is a destination of	Need to build in *Developing Workforce Safeguards* for visibility at Trust Board on safe staffing across the Trust and staffing metrics – to be completed by close Q2 Understand impact of Covid-19 on education and training, future timelines for trainees, as well as building up organisational capacity for education, training and supervision – undertake assessment through WECC by end Q3	**12**	**12**	**12**		4 x1 = 4	**<u>Positive assurance</u>** Recruitment was in a positive position prior to Covid-19; Covid-19 brought in ability to recruit retired staff and qualifying students quickly Staffing levels subject to daily review during pandemic; risk assessments and support put in place for all staff, staff supported by testing, working from home and ability to shield without affecting pay There are plans to restart virtually the 'Great Leaders' Be Remarkable and Bitesize programmes in October 2020 Introduction of 'virtual classrooms' to ensure medical education can continue during the pressurised Winter months A number of staff support services have been established to help staff through the second wave. These include Psychological, pastoral and occupational health services. Overall vacancies are reducing in line with the long term plan. Health and wellbeing programme commencing in December 2020, Great Leaders support clinics introduced. Schwartz rounds introduced. **<u>Further assurance required</u>** Absence remains 1% above 5 year average due to staff needing to self isolate and have tests due to Covid 19 like symptoms. Board Development Session to review: • staff availability and staff absence should there be a second wave of Covid-19 • Staff morale following environment changes due to the updated Capital plan

		availability due to Covid-19 including long-term trauma and burn-out Productivity decreases due to Covid-19 could place more demands on staff	Capacity of intra-vitreal injection service		choice during and following completion of training Nursing safety brief several times daily to ensure safe staffing numbers on each day Employment of additional junior doctor staff to fill junior doctor gaps Regular reports to the Trust Board from the Guardian of Safe Working Particular focus and investment in staff support during Covid-19 including mental health support Covid-19 redeployment undertaken with support of HGs and undertaken in a planned way					

Risk Appetite

There is a link between patient safety and finances; the Trust draws a 'red line' as compromising quality of care and has built in to the financial plan in 2018-19 and was carefully managed in 2019-20, which saw an increase in agency spend in order to maintain staffing numbers but also investment in new posts and new ways of entering nursing. The Trust needs to reduce the risk to its financial sustainability posed by quality and patient safety but without compromising the Trust's position on patient safety. The Trust is putting a plan in place to encompass new clinical training roles and build these in to workforce plans, so is demonstrating a good appetite to adapt and change to further mitigate this risk. The Trust has shown some agility and willingness to invest as part of this risk appetite but as a carefully managed financial position.

GOAL 3 – HIGH, QUALITY CARE

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 3	Chief Medical Officer Chief Nurse	Taken from the Trust's strategy: *The Trust has a well embedded approach to monitoring and improving the fundamental standards of nursing and midwifery care in its inpatient and outpatient areas* *Principal risk*: There Is a risk that the Trust is not able to make progress in continuously improving the quality of patient care and reach its long-term aim of an 'outstanding' rating *What could prevent the Trust from achieving this goal?* That the Trust does not develop its patient safety culture That Quality Improvement Plan is not designed around moving to good and outstanding That the Trust is too insular to know what outstanding looks like That the Trust	F&WHG – The Breast service reliant on one Pathologist due to long term sickness. Corporate: Time being taken to embed new clinical admin hubs	**4 (impact = major)** **4 – likely = 16**	New Quality Improvement Plan (QIP)I being put in place for 2020-21, focussing on key quality priorities, using project management methodology to set realistic goals to improve. The QIP will run throughout the financial year and monthly updates will be provided to the Quality Committee for confirm and challenge. New CQC action plan being put in place following publication of the partial inspection in June 2020; this will pick up on all 'should do' areas from the CQC, with each HG tasked with setting an action plan to address key points in their own areas Midwifery services have a robust plan to achieve the ambition in Better Births this is overseen at organisational and LMS level The Trust has put in place all requirements to date on Learning from Deaths framework over the last 3 years The Trust regularly monitors quality and safety data to understand quality of care and where further	Need to complete gap analysis against the national Patient Safety Strategy and implement a trust-wide action plan – by end Q2 Need to complete an updated Patient and Public Engagement plan and governance structure by end Q2 Need to assess impact on patient safety and clinical harm due to Covid-19 service delivery and service changes – by end Q1 Need to look at Board-level reporting on patient outcomes – by end Q3	**16**	**16**	**16**		4 x 2 = 8	**<u>Positive assurance</u>** Covid-19 has required temporarily cessation to some activities such as routine meetings; there is an opportunity to refresh the governance structure around patient safety and high quality care to continue in a lean, patient-focussed way Monthly update to the Trust Board on quality of care, monitored for Covid-19 as well as usual service delivery – no escalating risks on quality of care to report The Trust has undertaken a self-assessment against the NHSE Infection, Prevention and Control Board Assurance Framework. The CQC have reviewed the intelligence and have confirmed that the Trust has effective infection prevention and control measures in place in response to COVID and that the Trust continues to ensure that the health needs of patients and staff are met. 2 Never Events declared in April 2020 (relating to Robinson drains) had been downgraded and were now being investigated as serious incidents. No Never Events declared since April 2020. Covid Fundamental standards audits had commenced. **<u>Further assurance required</u>** Outcome of risk assessments/quality impact assessments on changes to patient pathways and delays to patient care in case these flag risks to patient harm The Trust has seen a slight increase in falls overall. In July 2020, agreement was made to re-focus the purpose of the Falls Prevention Committee. Focus Groups are to be introduced; primarily these will be set up in Elderly Medicine, and Oncology, where the highest numbers of falls are reported. The Elderly Medicine Group will focus on the link between falls and patients with Dementia or Delirium. Review of Ophthalmology eye injection service at the next Quality Committee – Backlog issues. A cluster of Serious Incidents relating to Covid-19 had been declared. The Trust was deciding whether to declare these as a cluster or individually. Plastics Service highlighted an increase in cancer

		does not increase its public, patient and stakeholder engagement, detailed in a strategy The impact on harm due to longer waiting times, delayed activity and less capacity from Covid-19 is not carefully managed. Capacity of organisation potentially compromised to be able to make Trust-wide improvements in quality of care			response is required Fundamental standards in nursing care on wards are being adapted for Outpatients. Will be monitored at the Trust Board and Quality Committee Participation in the "Moving to Good" Programme Close relationship with commissioners on clinical quality and improvement; have identified areas of partnership working on post-pandemic harm and patient waiting list management Regarding Falls - A monthly escalation report has been requested from each Health Group which will highlight to the Committee any increase/decrease in falls per ward, narrative around themes and trends, and any areas of concern and actions taken.					referrals and capacity issues impacting performance. Harm reviews had not been carried out due to capacity.

Risk Appetite

The Trust remains focussed on delivery of high quality services for its patients; the Trust does not want to compromise patient care and does not have an appetite to take risks with quality of care. The Trust acknowledges that the risk environment is increasing in relation to the Trust's financial position and ability to invest in services, and that the Trust has an underlying run-rate issue to address.

GOAL 4 – GREAT CLINICAL SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 4	Chief Operating Officer	Taken from the Trust's strategy: *The Trust is the only local provider of secondary emergency and elective healthcare services for a population of 600,000. These people rely on us to provide timely, accessible, appropriate care and look after them and their families at times of great vulnerability and stress.* *Principal risk:* There is a risk to access to Trust services due to the impact of Covid-19 1- There has been a deterioration in the Trust's performance on a number of key standards as a result of the organisation responding to Covid-19 2- There is a level of uncertainty regarding the scale and pace of recovery that is	F&WHG – Ophthalmology experiencing significant delays in meeting outpatient appointments F&WHG – Capacity for vitreal injections is limited. Clinical Support - Insufficient capacity in Radiology to accommodate increasing demand	**4 (impact = major)** **5 (likelihood = almost certain)** **= 20**	Quality Impact Assessments being undertaken on changes in service delivery due to Covid-19 Assessment per HG and service for Covid-19 recovery plans Clinical harm reviews process updated; service recovery plans require clinical review and prioritisation of all current patients on an open pathway; this includes reviews of harm if triggered Partnership working during Covid-19 and revised national guidance and emergency legislation reduced significantly Delayed Transfers of Care and hospital patients waiting packages of care Clinical triage of all new referrals to ensure patients/GPs receive advice and guidance and diagnostics where available whilst awaiting first appointment		**20**	**20**	**20**		4 x 2 = 8	**<u>Positive assurance</u>** New ways of service delivery adopted due to Covid-19, resulting in more efficient ways of working and ability to step activity back up in different ways, such as clinical triage of all new referrals, increased availability of advice and guidance, telephone consultations – ability to maintain these more efficient ways of working. This includes work with partners on hospital discharge processes and use of Urgent Care Centres as alternatives to ED Detailed briefing shared with Trust Board Development in July 2020 – Board fully sighted on waiting list position, recovery position, national requirements (as currently published) and the partnership working underway for service restoration COO and CMO meeting monthly with the Medical Directors to discuss ED performance and clinical engagement The Adopt and Adapt work for diagnostics is being progressed with the COO at HUTH being the SRO lead across HCV The triaging of the referrals in the RAS is working well for services. Positive engagement from all services to maintain and increase different ways of working across outpatient services Primary Care Collaborative Group had been established to review non-Covid harm The rapid increase in Covid admissions has impacted on urgent and emergency care and a reduction of the planned care programme to enable the conversion of elective wards to covid wards and mobilisation of the Covid surge staffing redeployment plan.

		possible and the impact of national guidance 3- Planning guidance being released in stages across the year What could prevent the Trust from achieving this goal? ED performance did improve following a period of intensive support and improvement focus but performance requires a Recovery and Improvement Plan to meet contractual requirements In all waiting time areas, diagnostic capacity is a specific limiting factor of being able to reduce waiting times, reduce backlogs and maintain sustainable list sizes; this is compounded by staffing and capital issues Ability to step back up activity following Covid-19 surge has rate-limiting factors on PPE and critical care capacity, as well as staff availability and patient availability			Impacts on waiting lists due to Covid-19 measured and published weekly Capacity and demand work in all pathways Plan to review medical base ward capacity to meet demand Restoration command structure in place						**Further assurance required** Results of Quality Impact Assessments and service plans to determine impact on waiting lists; realistic recovery times may be protracted and adding to already large waiting list Further work required on ED performance as patient numbers start to rise again – new weekly meeting in place between Health Group Medical Directors Following receipt of the Phase 3 planning letter there are risks around the performance expectations set out. Diagnostic performance is improving in July 2020, but there are still issues around endoscopy. Operating plan not meeting the national ask. Waiting list forecast March 2021 – 66000 52 week wait forecast March 2021 – 16500 ENT, Cardiology, Ophthalmology and Plastics were being reviewed due to them accounting for 40% of the backlog/waiting list issues. Cancer and 52 week performance is being impacted by the second wave of Covid-19.

Risk Appetite

A range of plans were put in place to further manage these issues in to 2019-20. The Trust wants to decrease waiting times as the particular concern in this is the anxiety and concern caused to patients having to wait. This concern has increased significantly in light of actions required during the Covid-19 first surge. Whilst there is an opportunity to use technology to a greater extent and make pathways more efficient, the Trust will need to consider how to make improvements in waiting times without compromising quality of care; this will need to fit in to the resource envelope when the financial plan for the year is confirmed. There is an appetite to take risks if this would improve quality of care and use resources more efficiently; this will require innovation as well as consideration of pathway change, some of which may need to be bigger schemes. This will require risk-sharing across system partners, which is yet to strongly emerge in practice.

GOAL 5 – PARTNERSHIP AND INTEGRATED SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 5	Director of Strategy and Planning	Taken from the Trust strategy: *In our strategy we have made a powerful commitment to work in a collaborative and proactive way, at all levels, to foster positive relationships with our partners and more closely integrate our services with other providers in primary, community and mental health and social care* *Principal risk:* That the Humber, Coast and Vale Health and Care Integrated Care System is not able to collectively make progress on developing and delivering integration due to Covid-19 recovery; momentum on work previously in progress could be lost *What could prevent the Trust from achieving this goal?*	None	**3 (impact = moderate)** **3 (likelihood = possible)** **= 9**	The Trust has key leadership roles in the current ICS governance structure – this has a breadth and depth of span and senior leaders from HUTH involved in all key groups, chairing many HUTH taking role in continued partnership work and asking for momentum on acute service reviews to be picked back up as soon as possible Undertaken detailed stakeholder feedback survey, and formulating action plan following Board discussion Recent discussions and plans on Humber Acute Services Review	Updated ICS framework for post-Covid-19 surge recovery to avoid duplication of work as well as to reflect ICS priorities on planning and delivery that have been interrupted by Covid-19 – timescales will be per ICS but likely to be concluded in Q3 Ongoing discussions on accountability framework at ICS level, the statutory duties of each ICS member organisation and the governance structures underpinning these – require continued discussion in 2020-21	**9**	**9**	**9**		3 x 1 = 3	**Positive assurance** Output of Humber Acute Services Review Interim Clinical Plan will move forward partnership working ICS status and new meetings bringing together acute providers to work more collaboratively HUTH/NLAG reviewing service models to improve services across the Humber region HUTH is the Covid vaccination hub for the HC&V area and would be in a position to go live by 1st December 2020. Covid vaccination programme commenced. **Further assurance required**

Risk Appetite
The Trust may need to take some risks in order to secure the correct strategic positioning; however, this would not be to compromise the Trust's strategy or delivery to patients; this area if an emerging picture and the Trust is positioned to play a key role in ICS developments and the way in which this delivers better quality care across the local health economy

GOAL 6 – RESEARCH AND INNOVATION

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 6	Chief Executive Chief Medical Officer	Taken from Trust strategy: *Our purpose in developing a new long term goal of 'great research and innovation' is to demonstrably improve the lives of the population we serve, by establishing the Trust as a nationally recognised research centre of excellence, with a culture of innovation* *Principal risk:* There is a risk that the Trust does not develop make progress in developing its research capability, capacity and partnerships *What could prevent the Trust from achieving this goal?* Scale of ambition vs. deliverability Current research capacity and capability may be a rate-limiting factor Unknown impact of Covid-19 on partner organisation and	None	**3 (impact = moderate)** **4 (likely)** **= 12**	Strengthened partnership with the University of Hull Trust investment in last 12 months in research capability including jointly funded posts and projects Actions against Strategic Goals within Trust Strategy for Research and Innovation in place – detailed plan in place with milestones and risk assessment Further development of partnership with Sri Ramachandra, India and joint research conference and projects	Understanding impact of Covid-19 in the short- and long-term on Trust's strategy as well as key partners – likely to understand position by close Q3 Understanding relationship and impact on clinical quality and patient outcomes with Trust's R&I and clinical audit activities – to have framework for updating/reporting at high level by end Q3	**12**	**12**	**12**		3 x 2 = 6	**Positive assurance** Trust taking part in Covid vaccination trial Trust working with HC&V to identify mutual benefits across the system Successful portfolio of Covid studies managed in 2020 HUTH Hull City Region Vaccine Hub. Funding received to support the delivery of the vaccine trials Non Covid research to commence where possible and safe to do so **Further assurance required** Junior Doctors and Research Fellows research time impacted due to Covid and clinical responsibilities

		research funding availability Recovery of Trust research staff redeployed during Covid-19 into front-line roles back in to research work									

Risk Appetite
As stated above, the Trust needs to balance the risk of investment in R&I capacity and capability against competing priorities, with its organisational reputation and the benefits that being a research-strong organisation will bring, in relation to funding, clinical service development and recruitment of high-calibre staff; there is an appetite to innovate in this area and go on a journey of development

GOAL 7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.1	Chief Financial Officer	Taken from the Trust Strategy: *The last 3 years have been a time of significant financial constraint; in the NHS as a whole, for our commissioners and also for the Trust. As at the end of 2018/19, the Trust is carrying a recurrent deficit of circa 5% of its operating budget. The NHS Long Term Plan sets out an approach to returning NHS providers to surplus over the next 5 years; we would expect to achieve a return to surplus early in the 5 year period and go on to sustain this.* *Principal risk:* There is a risk that the Trust does not achieve its financial plan for 2020-21 *What could prevent the Trust from achieving this goal?* Inability of Trust to restrict Covid related expenditure to within nationally prescribed expectations Inability of Trust to	Corporate: Pensions	**4 (impact = major** **3 (likelihood = possible)** **= 12**	HG held to account on financial and performance delivery at monthly Performance reviews; HGs hold own performance meetings Ongoing management of Trust cash balances to ensure no liquidity issues. Process in place to agree level of activity planned for remainder of year. Cannot be concluded until financial envelope known Monthly analysis and interrogation of Covid and non-Covid spend using established accounting processes and develop better understanding of the cost base Review of income generating activities taking place with assumption of charging for all relevant services (except staff car parking) from early September	Need to see financial plan from Centre to be able to frame the degree of risk and action required to achieve Assurance over grip and control of cost base; underlying run-rates increasing pressures Accurate forecasting and control Grip and control of locum and agency spend Delivery of recurrent CRES All above controls need to be addressed by end Q1	**12**	**12**	**12**		4 x 2 = 8	**<u>Positive assurance</u>** Monthly block contract arrangement and access to Covid-19 funding reported to Trust Board; Trust continues to monitor capacity and demand, income and cashflow in detail Achieved revised plan for first quarter of the year Financial planning guidance received for month 7 onwards Trust has maintained its break even position in Month 8 Trust has submitted a plan deficit of £6m based on shortfalls on other income such as car parking. The month 7 in month deficit of £0.52m was an improvement to the planned £0.7m **<u>Further assurance required</u>** Provider shares of the ICS Covid and growth allocations are still to be determined. ICS plans had been submitted. The risks were being reviewed. The ICS had a £8.9m gap to be addressed.

		generate income from non-clinical activities to pre-Covid levels Trust's desire to deliver activity levels above planned levels will generate a level of cost that is not covered by the nationally calculated plan for the period Prospective financial plan for periods (07-12) required excessive levels of cost reduction in order to meet plan									

Risk Appetite
The Trust is willing to review any CRES proposal and has a robust Quality Impact Assessment in place to understand any change posed to quality and safety as a result of a new CRES scheme. The Trust will not put in significant CRES schemes that would compromise patient safety. The aim of any CRES scheme is to maintain or ideally improve quality.

GOAL 7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.2	Chief Financial Officer	Taken from the Trust Strategy: *The last 3 years have been a time of significant financial constraint; in the NHS as a whole, for our commissioners and also for the Trust. As at the end of 2018/19, the Trust is carrying a recurrent deficit of circa 5% of its operating budget. The NHS Long Term Plan sets out an approach to returning NHS providers to surplus over the next 5 years; we would expect to achieve a return to surplus early in the 5 year period and go on to sustain this.* *Principal risk:* There is a risk that the Trust does not plan or make progress against addressing its underlying financial position over the next 3 years, including this year (year 2) *What could prevent the Trust from achieving this goal?* Lack of achievement of sufficient recurrent	None	**4 (impact = major)** **4 (likely)** **= 16**	Robust financial planning processes in place Covid-19 recovery planning already commenced Covid-19 funding available nationally, on a non-recurrent basis. Unclear what recurrent impact of Covid will be both in terms of income and expenditure	Need to update longer term financial plan – planning assumptions may change as well as ability of ICS to be able to meet all financial pressures of system Ability to deliver a 2-3 year plan to tackle underlying financial position relies on system-level control and contribution Need to agree a process to ensure resources are transferred appropriately between Trusts as a result of the developing acute service reviews	**16**	**16**	**16**		4 x 1 = 4	**Positive assurance** **Further assurance required** Emerging direction of travel for NHS Finance sees performance being measured at a system (ICS) level. It is not clear just how this evolving picture will impact on the Trusts underlying position.

		CRES or make efficiencies Unknown impact of Covid-19 finances and recovery planning National guidance not yet released for system financial planning during and post Covid-19								

Risk Appetite
The Board has an appetite to discuss a long-term financial plan to address the underlying financial position and to understand the risks that form part of the underlying issues as well as potential solutions. This is becoming an increasing priority.

GOAL7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.3	Chief Financial Officer	*Principal risk:* There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability *What could prevent the Trust from achieving this goal?* Lack of sufficient capital and revenue funds for investment to match growth, wear and tear, to support service reconfiguration, to replace equipment; capital funding is not available against the Trust's critical priority areas but is available in others, making the capital position look more manageable than operational reality	None	**4 (impact)** **3 (likelihood) Possible = 12**	Risk assessed as part of the capital programme Comprehensive maintenance programme in place and backlog maintenance requirements being updated Ability of Capital Resource Allocation Committee to divert funds Service-level business continuity plans Equipment Management Group in place with delegated budget from Capital Resource Allocation Committee to manage equipment replacement and equipment failure requirements – managing critical and urgent equipment replacement in 18-19 Business case for Wave 4 STP capital completed. This will enable some infrastructure risks in 2020-21 to be addressed Combined Heat and Power Plant capital funding sourced in 2019-20 – CHP being commissioned in 20-21 Critical infrastructure funding of £6m received to help reduce	Insufficient funds to manage the totality of risk at the current time – unable to address internally	**9**	**9**	**9**		4 x 2 = 8	**<u>Positive assurance</u>** Increased capital plan for 2020-21, successfully application for additional capital funding to address some long-term infrastructure needs The Capital Resource Allocation Committee were informed that the Government has announced an additional £600m capital to address high risk critical infrastructure backlogs. This funding is to improve estates resilience and is expected to deliver maximum reduction in reported critical infrastructure risks (CIR). The HCAV's proportion of this bid is £14.9m for critical care infrastructure, with HUTH's proportion being £6.2m. HCaV Urgent and Emergency Care Business Case Update has progressed to NHSEI and DHSC for evaluation. Difference to the original plan (£18.6m) discussed at the Trust Board meeting in September 2020. Works have started although the MOU is yet to be received. Finance teams are confident that the Trust will spend the capital allocations by 31 March 2021. **<u>Further assurance required</u>** Building works for the updated Capital programme and the impact on services and staff.

					backlog.					

Risk Appetite
The Trust is balancing a number of risks in relation to capital; the amount of capital available to the Trust is very limited compared with the calls on capital that the Trust has quantified –i.e. backlog maintenance, equipment replacement, capital development requirements for safe patient environments, quality of sanitary accommodation; the longer the Trust manages its estates as it is, the increase of non-compliance risks with regulatory requirements

Hull University Teaching Hospitals NHS Trust

Trust Board

January 2021

Title:	Our Patients - Performance Summary	
Responsible Director:	Ellen Ryabov - Chief Operating Officer	
Author:	Ellen Ryabov - Chief Operating Officer	
Purpose:	The purpose of this paper to provide an Executive Summary of Performance for November 2020 against national standards.	
BAF Risk:	BAF 4 – Performance	
Strategic Goals:	Honest, caring and accountable culture	
	Valued, skilled and sufficient staff	
	High quality care	X
	Great local services	X
	Great specialist services	X
	Partnership and integrated services	
	Financial sustainability	
Key Summary of Issues:	The Trust has seen a general deterioration across a number of the Unplanned and Planned Care Standards during November when compared with October 2020. Work continues with each of the Health Groups to develop, agree and implement the agreed recovery plan to the end of Q4 as part of the revised Phase 3 plan submission. There was a marginal improvement in the Cancer 62 day performance for November. The Faster Diagnostic Standard continues to be achieved. As a result of the continued increase in Covid admissions to hospital significant pressures are being seen across the urgent and emergency pathway with the resultant reduction of the planned care programme to support our urgent care work.	
Recommendation	That the Trust Board receives and accepts the content of this paper and indicates whether any further assurance is required.	

Performance Report - Executive Summary

December 2020

1. Purpose

The paper provides an executive summary on actual delivery towards key performance standards for November 2020 against the planned national standards.

Performance against all 'responsiveness' indicators is monitored at the Performance and Activity Meetings, chaired by the Chief Operating Officer. A Summary of Key Performance Standards is shown at Appendix 1.

2. Phase 3 Planning - Q4 Trust Response Under Revision

The national guidance on Phase 3 planning was issued in August and set out the expectations for the NHS to return to 'near normal' levels of non Covid health services. In summary those expectations were;

- **Day Case and Electives**: That for September, Trusts should deliver 80% of last year's activity rising to 90% in October.
- **Diagnostics**: That Trusts (and system's) achieve 90% of last year's activity for MRI, CT and Endoscopy with a goal of reaching 100% by October 2020.
- **Outpatients**: That Trusts deliver 100% of last year activity for first outpatient attendances and follow-ups from September and for the remainder of the year.

The Trust plans set out in October identified that for the period September to March the Trust expected to deliver 83% electives against the 90% requirement; 88% for diagnostics against the 100% target and 92% Outpatient activity against the 100% target.

Following the second Covid surge mid-October, steps are underway within each Health Group to revise all phase 3 planning assumptions and this work is expected to be completed mid-January 2021. It is fully expected that the continuing increase in patients being admitted with Covid illness will significantly impact our elective capacity, primarily as a result of staff redeployment, staff sickness and those isolating as a result of Covid.

In order to mitigate the ongoing risk, the aim is to move as much planned work as possible into the independent sector, and to also make full use of outpatient and day-case settings where this level of work can be resourced and safely delivered.

HUTH Agreed Phase 3 Recovery Objectives

- Ensure all P1a and P1b work is completed on time
- Ensure all P2 cases are validated/confirmed as P2
- Maximise operating capacity to ensure all validated P2 work in completed within 4 weeks of decision to treat
- Completion of all P2 MDT directed cancer work within 4 weeks

- Reduction of 104w breaches to zero and hold
- Reduction of 52w backlog to zero and hold – specialty level trajectories in development
- Reduce overall waiting list size below current levels for outpatient and day case

Main risks to delivery of P2/all other elective work

- Covid capacity planning for > 200 beds to accommodate 3rd Covid surge
- Workforce redeployment > 100 theatre staff to accommodate above
- Workforce sickness absence potential to increase
- Need to balance oxygen usage between CHH and HRI sites
- Critical care capacity/workforce
- Increasing Covid workload due to support wave 3 peak – expected early to mid-Jan 21

A more detailed update on the expected impact of Covid on our elective workflows and activity will be provided in a separate update to the Board in February 2021.

3. Unplanned Care

3.1 The Trust has seen a general deterioration across a number of the Unplanned Care Standards during November when compared with October. Delivery of our 4-Hour Performance for the month of November was 77.7% (Types 1 & 3 combined) compared with 82.2% for the month of October.

3.2 Ambulance handover times are broadly similar with 1742 ambulances in month waiting in excess of 15 mins (1713 in October) however those waiting between 30-60 mins and over 60 mins have increased significantly month on month with those over 60 mins seeing the greatest increase up from 171 in October to 304 in November.

3.3 Flow throughout the Emergency Department has continued to be significanlty compromised throughout November as the department responds to increasing numbers of suspected and confirmed Covid admissions, as well as an increase in the length of time patients are in the ED waiting for Covid results before they can be safely placed in the appropriate environment and pathway within the hospital.

3.4 The Trust continues to report Zero 12 hour trolley waits.

3.5 The Trust monitors the overall time that patients spend within the Emergency Department as this is a key quality metric recommended by Getting it Right First Time (GIRFT) and the Royal College of Emergency Medicine. For November, 21.7% of patients spent longer than 6 hours in the ED, a deterioration of 4.4% on the previous month.

3.6 However the median time between arrival in ED and treatment has remained broadly static over the 4 months, with November showing a slight increase to 68 minutes.

3.7 Overall length of stay in the ED is monitored via the Emergency Department and Flow Performance and Activity meeting.

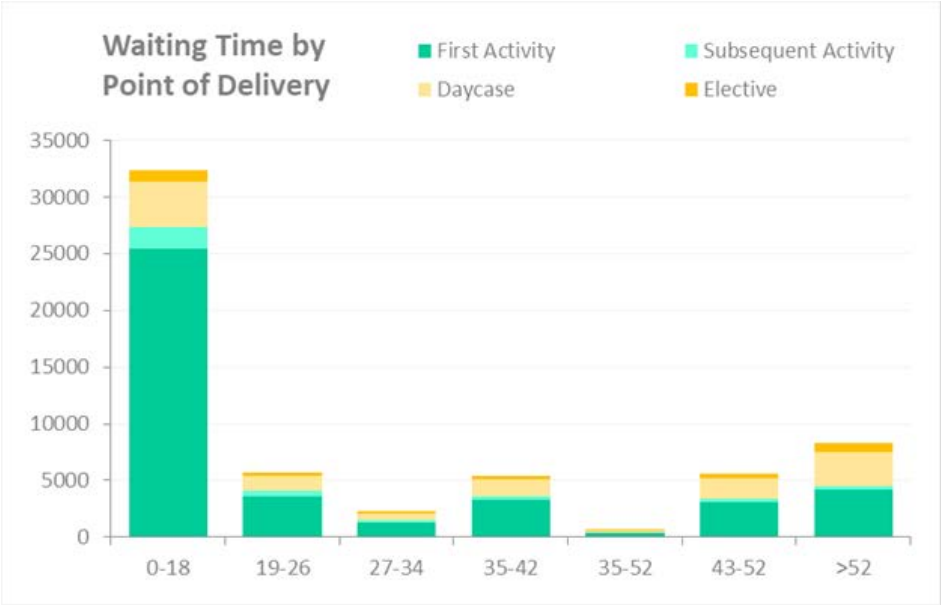
4. Planned Care

4.1 The position on Planned Care standards during November is broadly comparable with that seen in October and whilst the actual RTT incomplete performance has improved marginally to 51.8% (compared to 49.9% in October) and the diagnostic waits have improved to 34.8% (compared to 34.2% in October) the general trend on planned care standards is one of deterioration.

4.2 The total list size, long waiters over 36 weeks and those over 52 weeks all continue to show a significant increase with those over 52 weeks reaching a new high of 8022 in November.

4.3 It should be noted that the majority of our waiting list is driven by those patients waiting first appointment and this will be the focus of our recovery plans going forward:

Table 1



4.4 Likewise the breakdown by speciality demonstrates the Top 10 most challenged by point of delivery over 52 weeks and our focus will also be on these areas going forward:

Table 2

5. Diagnostics

5.1 Performance against the diagnostic 6 week standard was 34.8% (against the 1% standard) which is broadly similar to that seen in October 20

6. Cancer Standards

6.1 The Trust position on the 2WW standard for November saw an improvement to 81.3% for patients seen within 14 days, against the 93% standard. The Breast Service remains challenged and further work to improve this will be undertaken with the Family & Women's senior team.

6.2 Performance against 62 day standard saw a marginal improvement to 62.2% up from 61.2% for September. Work is being carried out in conjunction with the CCGs to understand the increased number of referrals in the Top 10 GP practices across Hull & East Riding.

7. Conclusion.

The Trust has saw a rapid increase in the number of patients being admitted with Covid illness in the period mid-October through to the end of November and the impact of the pandemic on our urgent and emergency workload continues.

The result of the ongoing pandemic is that we are now seeing significant pressures on our urgent and emergency care pathways, which when combined with our normal winter pressures has, and will continue, to reduce our ability to fully recover our planned care programme.

It is important that we do as much work as we can on the elective care programme and each Health Group will continue to develop a robust plan to enable that to take place through to the end of Q4, the key risk to achievement of these plans will undoubtedly be the necessary staffing resource to deliver them.

Ellen Ryabov
5 January 2021

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
QUALITY REPORT

PREPARED FOR THE TRUST BOARD
December 2020

Title:	Quality Report: Patient Impacts
Responsible Director:	Beverley Geary - Chief Nurse
Author:	Beverley Geary - Chief Nurse

Purpose:	The purpose of this report is to provide information and assurance to the Trust Board to matters relating to quality governance and patient safety including: • Nursing Quality Review • Risk Management • Patient Safety • Patient Experience • Well-led domain	
BAF Risk:	BAF 3 – Quality of Care	
Strategic Goals:	Honest, caring and accountable culture	
	Valued, skilled and sufficient staff	
	High quality care	X
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	
Summary Key of Issues:	This report provides information on key quality indicators. Exceptions are noted in more detail throughout the report in relation to: • IPC current position • There were 7 serious incidents declared in November 2020. • The Trust has had 0 grade 4 pressure damage in November 2020. • The overall number of patient falls has decreased in November 2020. • 37 complaints were opened in November 2020, • 174 PALS enquiries were received within November 2020 • The Trust responded to the request for futher action following the publication of the first Ockenden report to confirm compliance with the (7) immediate and essential actions and 12 urgent clinical priorities	
Recommendation:	The Committee is asked to receive the report as assurance on the quality of care being delivered in the Trust and that mechanisms are in place to record exceptions and mitigate risks.	

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
TRUST BOARD

Patient Impacts

1. PURPOSE OF THIS REPORT

The purpose of the report is to apprise the Board of the key issues in relation to quality governance, patient safety and regulatory matters.

2. NURSING QUALITY REVIEW PROCESS

As in wave one of the pandemic a decision has been made by the senior nursing team to step down the core fundamental standards whilst the Trust is in a state of escalation, in response to COVID -19. In order to ensure quality of care and to continue the monitoring and operational processes, with regards to quality, adaptations were made to existing nursing assurance processes during wave 1 and reintroduced during wave 2 of the COVID -19 pandemic.

2.1 Covid Fundamental Standards

To ensure all aspects of quality are reviewed, specifically relating to COVID – 19 the Senior Nursing Team have developed and introduced a fundamental standard which reviews the following areas:

- Infection Control with a specific focus on PPE and Hand Hygiene
- Staff Knowledge in relation to COVID and required processes.
- Staff and Patient Experience

The results were obtained through the completion of the standard during July, August, September and October 2020, these are reported through the Nursing, Patient Experience, Effectiveness and Safety (PEES) meeting which is attended by all of the Nurse Directors and relevant nursing leads. Areas of non-compliance are identified, discussed with the clinical teams and action plans developed to support improvement in practice.

In order to support the clinical areas that are nursing COVID patients and enhance the quality of care provided to this patient group, the Senior Nursing Team have developed and introduced a Core Care plan and specific `Intentional Rounding` document which is underpinned by the evidence provided by the British Thoracic Society et al (2020)1.

2.2 Operational Processes

From an operational perspective a daily safety huddle is held with all senior matrons, PDM`s and Nurse Directors, in order to provide a forum for the delivery of any key messages and the identification of any issues that require escalation through the Trusts Command Structure. In addition the Senior Nursing Team hold a team brief three times a week for all ward sisters/charge nurses to delivery key messages with regards to the Trusts Surge plan, staff redeployment and any issues pertaining to COVID -19, particularly in relation to staff training and any quality issues/concerns.

These processes have been implemented to provide assurance to the Senior Nursing Team regarding the quality of care during the COVID – 19 pandemic. This is further supported by the introduction of a robust `Ward to Board` communication strategy, to ensure all key messages are delivered across all nursing teams within the Trust.

3. RISK MANAGEMENT

3.1 Never Events and Serious Incidents

During November 2020 there were 0 Never Events and 7 Serious Incidents declared. The Duty of Candour process has been initiated in all cases.

The incidents were:

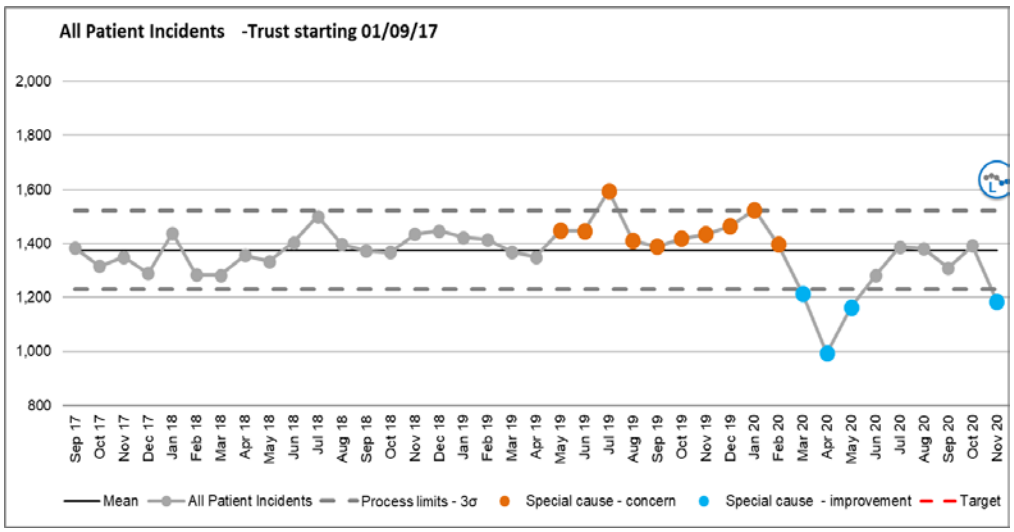
- There were 2 potential delayed diagnosis
- 2 Patient falls resulting in fracture
- Specimens obtained during a routine surgical procedure were not available for testing in pathology
- Maternity incident involving woman at 21 weeks gestation
- There is a potential treatment delay for a patient's wet AMD within ophthalmology

Themes and trends from Serious Incident and Near misses are routinely reviewed at the SI Committee. Trend analysis is undertaken and reported to the appropriate committee, most recently; ophthalmology incidents and a maternity thematic review.

3.2 Incident Reporting

Whist incident numbers continue to fall, of note is the increase above control limits of moderate and above patient safety incidents per 1,000 bed days.

Figure 1: All patient incidents, injury or adverse outcome – Moderate and above per 1,000 bed days



4. PATIENT SAFETY

4.1 Healthcare Associated Infections

MRSA

No Trust apportioned MRSA bacteraemia cases have been reported from the 1st April 2020 until the 30th November 2020. On the 22nd June 2020, a community apportioned case was reported and investigated via a Post Infection Review.

MSSA

6 MSSA cases were reported in November – bringing the total to 37 to date. All Trust apportioned cases are investigated using a root cause analysis (RCA) process. A review of MSSA bacteraemia cases up to and including August 2020 identified that 42% were associated with vascular devices. A further review will be completed in January 2021. In the forthcoming months a change in the type of cannula will be introduced along with the products to support insertion of cannulas.

Clostridium difficile

During November 2020, 2 Hospital onset healthcare associated *Clostridium difficile* cases were reported along with 4 community onset healthcare associated cases which is being investigated by the Trust using a root cause analysis process. By the end of November 2020, there have been twenty nine HOHA cases reported and fifteen COHA cases. All Trust apportioned cases are investigated using RCA.

E.coli bacteraemia

During November 2020, 6 Trust apportioned, E.coli bacteraemia were reported, this equates to 64 cases year to date. November figures demonstrates a reduction in monthly reported cases. The same trends and sources of infection continue to be identified, these are biliary, urinary and respiratory. By the end of November 2020, there have been 64 Trust apportioned cases.

Klebsiella bacteraemia

4 Trust apportioned Klebsiella bacteraemia cases were reported during November 2020, representing 16 year to date. Each case is subject to a review and if lapses in practice are identified then a RCA is required. The same trends and sources of infection continue to be identified, being biliary, urinary, respiratory and intra-abdominal.

Pseudomonas aeruginosa bacteraemia

2 Pseudomonas aeruginosa bacteraemia cases were reported during November 2020 and are associated with ventilated associated pneumonia, one of which secondary to COVID-19. Each case is subject to a review by the IPCT and if lapses in practice are identified then a RCA is required. Similar themes as noted above.

Additional information

To date there have been a number of bay closures due to D&V but no full ward closures and norovirus as a causative organism has not been reported. During bay closures and increase in faecal sampling, incidental findings of Clostridium difficile cases have been reported.

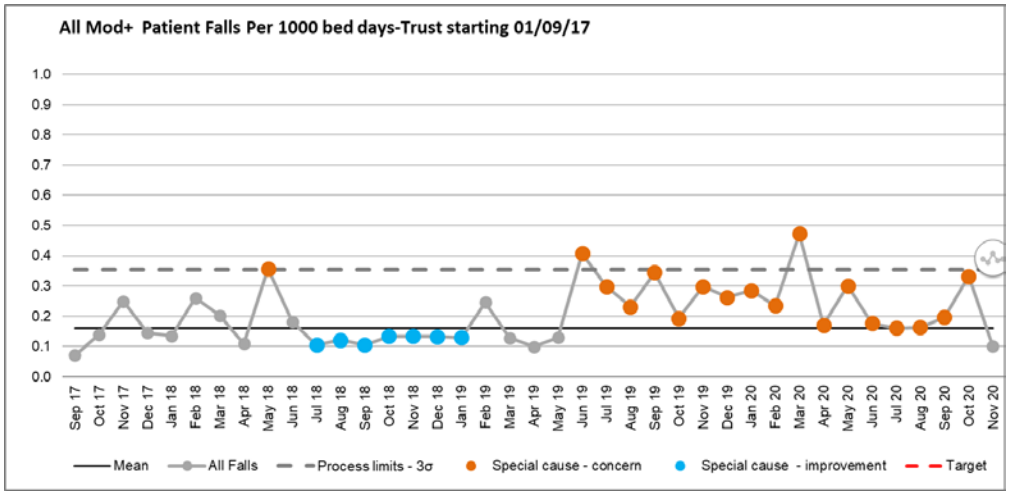
The national screening requirement for Covid-19 is that all patients are screened on admission to hospital. In addition, screening on day 5-7, and a discharge planning screening.
Recently PHE have strongly advised that day 3 screening should be undertaken to identify patients who could possibly have been incubating the virus on admission. The day 3 screen was introduced on cold medical wards in December and we are planning to roll this put to all ward areas.
The likelihood is that we will be an increase in incidence in our in-patient bed base; however this will identify more cases earlier and reduce hospital transmission.

4.2 Falls

There has been a decrease of overall number of patient falls, as well as the falls resulting in moderate or above harm. The decrease is the most significant since May 2019 and is reflected across all of the Health Groups; with the exception of Surgery, although the rise in numbers reported in SHG is minimal.

September	October	November -
Minor – 29	Minor – 50	Minor - 32
Moderate – 1	Moderate – 1	Moderate - 1
Major – 5	Major – 6	Major - 2

Figure 2: All patient falls per 1,000 bed days



4.3 Pressure Damage

In November the Trust reported 33 pressure ulcers (Category 2 and above), 11 device related pressure ulcers (Category 2 and above) and 26 moisture associated skin damage.

Pressure Ulcers (PU) - The Trust has reported one Category 3 PU (no Category 4 PU). Reported Deep Tissue Injury remained the same as the previous month (DTI = n9), there were 2 reported Unstageable PU and a significant increase in reported Category 2 PU's (C2 = n21).
To date 50% of the incidents have been investigated within the recommended 14 day timeframe. Positive findings included regular pressure ulcer risk assessments, good completion of body maps on transfer and delivery of Sskin care bundles. Areas which require improvement are individual planning of care needs, completion of wound care charts, escalation of concerns, recordings of weight and food record charts.

Device Related Pressure Ulcers (DRPU) – The Trust reported no Category 3 or 4 DRPU's. There were 2 Deep Tissue Injury, 2 Unstageable and 7 Category 2 DRPU's reported. The devices causing the injuries included anti-embolic stockings, O2 delivery face masks (NIV, CPAP), catheter tubing, plaster cast and ET tie. To date 50% of the incidents have been investigated within the recommended 14 day timeframe. Lessons learned were mainly based on the quality of the documentation. Planned care for the medical device was missing in some incidents which led to a lack of interventions to care for the skin under/around the device and nursing evaluations lacked evidence of skin review and escalation of concerns.

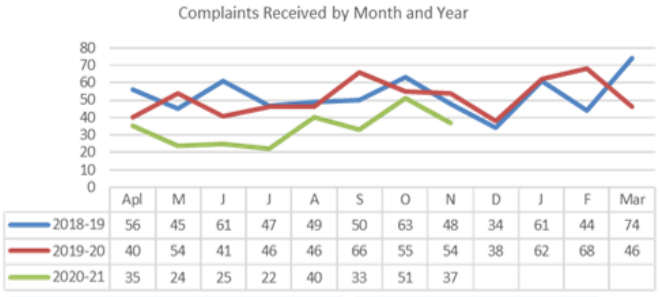
5. PATIENT EXPERIENCE

37 complaints were opened in November 2020, a reduction from the 54 opened in October 2020. The numbers remain below the figures for the same period in 2018-19 and 2019-20. Of the complaints that were closed in November 2020 (41), 27 (66%) were closed within the 40 day target.

174 PALS were received within November 2020. The primary subjects were: patients not satisfied with care plan, waiting times in outpatients, and communication concerns. These are the same primary subjects as in previous months.

Complaints by Health Group and Subject (primary)	Advice	Attitude	Care and Comfort	Communication	Delays, Waiting times and Cancellations	Discharge	Environment	Hotel	Safeguarding	Special Needs	Treatment	Total
Corporate Functions	0	0	0	0	0	0	0	0	0	0	0	0
Clinical Support	0	0	1	0	0	0	0	0	0	0	1	2
Emergency & Acute	1	0	0	0	0	1	0	0	0	0	4	6
Family & Women's	0	0	0	1	1	0	0	0	0	0	8	10
Medicine	0	1	1	3	0	2	0	0	0	0	3	10
Surgery	0	1	0	0	1	0	0	0	0	0	7	9
Totals:	1	2	2	4	2	3	0	0	0	0	23	37

Currently Open (30.11.20)	Complex or needs clinical input	Under Investigation – no problems anticipated	Ready for closing in the next 3 days
76 complaints are currently open and under investigation	7 cases are complex and require clinical input. 18 cases have been opened over 40 days	61 cases under investigation and no problems anticipated. (note 11 cases have been received in the last 7 working days).	8 cases are in draft or ready for signature.



September 2020	N° Closed	Within 40 days	Upheld	Partly Upheld	Not Upheld	Not Inv	Re-opened	Dis-satisfy
Corporate Functions	0	0 (100%)	0	0	0	0	0	0
Clinical Support	2	1 (50%)	0	2	0	0	1	1
Emergency Medicine	9	6 (66%)	3	4	1	1	2	2
Family and Women's	6	5 (83%)	0	4	1	1	1	1
Medicine	16	10 (62.5%)	7	9	0	1	4	4
Surgery	10	5 (50%)	2	6	2	1	1	1
Totals:	41	27 (66%)	12	25	4	4	9	9

Complaints by Location - Top (5)	
ED, Majors	5
Ward 30, Cedar WCH	3
Ward 10, CHH	2
Eye Clinic	3
Ward 9, CHH	1
Totals	13

Vulnerabilities	
Dementia	5
Cognitive Impairment	3
Sensory Impairment	2
Total	10

6. WELL-LED

6.1 The Ockenden report

On December 10th the Ockenden report on the emerging findings and recommendations into the independent review of Maternity Services at the Shrewsbury and Telford hospital NHS trust was published. The following week all Chief Executives were asked to assess services against a number of (7) immediate and essential actions and 12 urgent clinical priorities and to submit a return to the LMS and NHSI by 21.12.20 to confirm compliance. This was completed and submitted within the requested timeframe.

The letter and submission is detailed in a separate paper to Board.

7. RECOMMENDATION

The Trust Board is recommended to receive and accept the updates provided in this report.

Hull University Teaching Hospitals NHS Trust

Trust Board

12 January 2021

Title:	Ockenden Maternity Review – Urgent Action
Responsible Director:	Beverley Geary – Chief Nurse
Author:	Beverley Geary – Chief Nurse

Purpose:	The purpose of the documents is to provide assurance to the Board that the Trust is meeting all of the Immediate Essential Actions set out in the letter from NHS England/NHS Improvement received 14th December 2020.	
BAF Risk:	BAF Risk 3: Quality of Care	
Strategic Goals:	Honest, caring and accountable culture	
	Valued, skilled and sufficient staff	
	High quality care	✓
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	
Summary Key of Issues:	The Ockenden report on the emerging findings and recommendations into the independent review of Maternity Services at the Shrewsbury and Telford hospital NHS trust was published on 10th December 2020. Following the publication all Chief Executives; in Trusts with maternity services, received a letter from were asked to assess their services against a number of immediate and essential actions (7) and 12 urgent clinical priorities and to submit a return to the LMS and NHSI by 21.12.20 to confirm compliance. Attached is the initial response required by NHSI to be submitted to them by 21.12.20, this was also submitted to the Local Midwifery System. Given the rapid turnaround time this was previously briefed to board members ahead of submission. In addition, an assessment against the national is attached for assurance. Work is ongoing to provide continuing assurance to the Board and the LMS.	

Recommendation:	The Trust Board is asked to accept the Trust's response to the Ockenden Report and assurance around the 7 Immediate Essential Actions.

Hull University Teaching Hospitals NHS Trust

Amanda Pritchard
Chief Operating Officer, NHS England and NHS Improvement &
Chief Executive, NHS Improvement

Cc:

Danielle Lax;
Regional Maternity Transformation Programme Manager (North East & North West)

Dr Tracy Cooper
Chief Midwife for North East & Yorkshire, NHS England (North East & Yorkshire)

21st December 2020

Dear Colleague;

RE: OCKENDEN REVIEW OF MATERNITY SERVICES – URGENT ACTION

Thank you for your letter dated 14 December 2020 requesting assurance from Hull University Teaching Hospitals NHS Trust (HUTH) as to the quality and safety of our Maternity Services against the 7 Immediate and Essential Actions (IEAs) of the Ockenden Review; and specifically the 12 urgent clinical priorities.

We have reviewed each of the 12 urgent clinical priorities from the IEAs; our assurance assessment and the supporting details as summarised below:

	Assurance Assessment	**Comments**
1: Enhanced Safety	**Overall; Yes**	
a) Perinatal Clinical Quality Surveillance Model	Yes	HUTH implemented the Perinatal Mortality Tool [PMRT] from April 2018 in line with National Guidance. The completion of the tool is undertaken through an MDT approach and we are currently compliant with all four standards, and this has been the case on a quarterly basis since inception.
b) SIs shared with Boards/LMS/HSIB	Yes	All Serious Incidents declared in maternity services are noted in the Trust Board Quality Report. All draft Serious Incident reports are presented at the Trust's Serious Incident Committee (chaired by the Chief Nurse and deputy chair CMO). The reports are scrutinised and approved in this forum; this forum also notes any repeat themes and lessons learnt.

		All Serious Incidents are summarised and circulated across the Trust in the form of global email and discussed at Health Group Governance Meetings. All maternity SI cases that meet the HSIB reporting criteria have been submitted to HSIB – these are generally reported within 72 hours. We have continued to report all cases to HSIB during the response to the Covid pandemic – with HSIB selecting cases of confirmed diagnosis HIE Grade 2 or above for full investigation. A process has been agreed that from January 2021 all Maternity SI's will be reported to Trust Board monthly.
2: Listening to Women and their Families	**Overall; Yes**	
a) Robust service feedback mechanisms	Yes	Currently there are two active Maternity Voices Partnerships (MVP) operating within the Hull and East Riding region. The Hull MVP has been in operation since 2018 and in East Riding since May 2019. Annual events held over the last two years (Hull in 2019 & Goole in 2020) both used the 'whose shoes' tool to engage and listen to women who have used our services. From listening to women, both events identified opportunities for improvements in maternity service; the identified improvements included: • Developed a virtual tour showcasing the maternity offer at HUTH using modern virtual reality technology – this was implemented with effect from October 2019. • Implemented a monthly carousel event with key stakeholders as "a one stop shop" to enable women to receive important information such as choice of place of birth, feeding choices, immunisation, safe sleeping demonstrations as examples; these events commenced 2018. Due to the Covid pandemic these events

		have been suspended. However, work is underway to develop and publish videos based on the key public health messages with a view to publishing them on an accessible website. We expect this to be finalised by March 2021. All of the '*whose shoes'* event actions have fed back into the postnatal and choice/personalisation work streams which seek to involve women in co-production of care.
b) Exec/Non-Exec directors in place	Yes	HUTH has an identified Non-Executive Director whose role and responsibilities will be developed and refined in line with issued guidance to support the Board maternity safety champion (Chief Nurse).
3: Staff training and working together	**Overall; Yes**	
a) Consultant led ward rounds twice daily	Yes	The position for HUTH at 17 December 2020 is that a consultant-led ward is undertaken every morning seven days a week; with the resident consultant undertaking a ward round on Friday, Saturday and Sunday nights. With immediate effect (18 December 2020) we have implemented twice daily ward rounds Mon-Thurs in response to this review which will be provided by the daytime consultant.
b) MDT training schedule	Yes	Mandated MDT training is organised/ integrated within a planned programme; this is resourced within job plans and midwife establishment of Hull maternity service. As part of the response to the Covid pandemic the last full day PROMPT course was completed on the 13/03/2020, after which dates all face to face teaching was cancelled. A reduced face to face PROMPT course was re-commenced on the 18/06/2020. This is a half-day session covering Maternal Resuscitation, Neonatal Resuscitation, Maternal collapse and post-partum haemorrhage (PPH) scenarios. Other theory content is now undertaken

		as online learning on the K2 programme until the service can reinstate a full day sessions. A number of on-ward emergency simulations were undertaken as part of the planning, revised procedures and testing of systems & processes during the pandemic including PPH, maternal collapse, eclampsia, neonatal resuscitation including an MDT of staff from all areas. Current overall compliance with MDT training is at 80% with a plan to achieve full compliance by May 2021.
c) CNST funding ringfenced for maternity	Yes	The service can confirm that the first 2 years of the Maternity Incentive Scheme (MIS) provided funding which was used to provide additional senior medical sessions to support caesarean section capacity and the provision of anaesthetic operating department practitioners to receive enhanced training. Both of these allowed the workforce to support the safety and delivery of the maternity service. In addition, funds were used to enhance the built environment enabling the labour ward, delivery ward and the MLU to deliver an elevated and consistent senior clinical management presence. In addition, funding that has been allocated for the training of maternity staff, (both pay costs to ensure the safety of the service and the cost of materials and facilities) is ring-fenced within the budgets for the duration of the finance year. The Trust has invested in initiatives such as Continuity of Carer on a recurrent basis and has used previous years' MIS allocations as part of the recurrent efficiency ask from the Maternity Service. The Trust will revisit the issue of how it treats future years MIS funding as part of its annual planning process.
4: Managing complex pregnancy	**Overall; yes**	
a) Named consultant lead/audit	Yes	Every woman risk assessed as a complex pregnancy has a named consultant and

		the risk assessments are reviewed appropriately.
b) Development of Maternal Medicine Centres	yes	Networked maternal medicine services include pre-pregnancy, antenatal and postnatal care for women who have significant medical problems that pre-date or arise in pregnancy or the puerperium. The service specification identifies that the maternity service would require 0.5 WTE Obstetrician (maternal medicine) (this role may be fulfilled in some units by a team of obstetricians; however there is an identified clinical lead for Obstetrics which is separate from the Clinical Director role. HUTH do not currently fulfil all of the service specification to be a Maternal Medicine Centre. However we do care for very complex women with a lead specialist obstetrician with appropriate clinical competency in maternal medicine. Whilst we care for the majority of complex women some are transferred to Leeds such as those women with severe cardiac complications. This is less than 10 women per year. HUTH are working with the Clinical Networks and the LMS to progress the ambition of Hull being a maternal medicine sub-centre in Yorkshire & Humber. This process is ongoing in line with national work.
5: Risk assessment throughout pregnancy	**Overall; Yes**	
a) Risk assessment recorded at every contact	Yes	Initial risk assessment via the booking in process utilising the HUTH Guideline: *422 – BOOKING APPOINTMENT & SUPPORTING ANTENATAL CARE GUIDELINE*. Using this guideline women are categorised on midwifery led or consultant led care pathway. Throughout the maternity journey women who deviate from the initial assessment are reviewed and re-categorised to the pathway accordingly.

		This information is captured and submitted via the MSDS data and reviewed monthly.
6: Monitoring Fetal Wellbeing	**Overall; Yes**	
a) Second lead identified	Yes	HUTH has implemented a 0.40 WTE lead midwife post in line with the Saving Babies Lives Care Bundle Version Two recommendations; the post-holder was in post February 2020. There is currently no lead obstetrician in post however there is an Obstetric Clinical Lead who is responsible for training. There has not been a previous requirement for a specific lead consultant for CTG; in order to implement this, the service would require 0.5 PA per week which will be actioned following clarification on receipt of the national guidance.
7: Informed Consent	**Overall; Yes**	
a) Pathways of care clearly described, on website	Yes	Patient information has been developed and is published on the Trust's maternity website pages - all key elements identified in the Chelsea and Westminster website have been included. A review of HUTH maternity information will be undertaken to share best practice by March 2021. As part of the trust's response to the Covid-19 pandemic, supported by the Maternity Transformation Board and local MVPs, the 'Ask The Midwife' messaging service was launched on 30th March 2020 in HUTH and then rolled out across the LMS. The purpose of this service is three pronged: - To provide an additional method for women to be able to gain advice from a registered midwife without face to face contact thus providing reassurance - To share consistent and accurate messages in relation to changes within the maternity services to a wide

		audience, especially important due to frequent guidance changes - To divert workload away from the clinical environment (either in the form of telephone calls or face to face attendances) so that staff in those environments can concentrate on providing clinical care The service is available via the Trust's existing women and children's Facebook page. This is used as a medium to share messages on a large scale and also to answer individual messages privately. To date, 7637 messages have been sent to the service, 173 public posts were made which were shared 3931 times and have received 4474 public comments.

As Chief Executive Officer of Hull University Teaching Hospitals NHS Trust, I am happy to confirm that we are meeting all these standards or have the relevant plans in place for onward work as requested.

This summary and the supporting gap analyses completed have been reviewed myself, the Chief Nurse and the Head of Midwifery.

They were subsequently considered and independently validated by Becky Case, Local Maternity System Programme Lead, and signed off on behalf of the Humber, Coast and Vale Integrated Care System by the SRO Beverley Geary, and Deputy SRO Sarah Smyth on Monday 21st December 2020.

Yours sincerely

Chris Long
Chief Executive

Maternity services assessment and assurance tool

We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

Section 1

Immediate and Essential Action 1: Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.

- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
1. Monthly PMRTmeetings and a quarterly report to the Trust Board 2. MSDS data is being submitted to the Maternity Services Dataset 3. All cases for 2019/2020 have been reported to the NHS Early Notification Scheme 4. The Trust will plan to implement the Perinatal Clinical Quality Surveillance Model from 1/1/2021	1. Associated monthly actions are tracked through the PMRT meetings. 2. MSDS data submission discussed every 2 weeks during CNST meetings 3. All HSIB cases and associated actions are discussed at speciality governance to identify learning and improvement opportunities.	1. Changes and amendments to clinical guidelines are made from PMRT/HSIB cases. 2. Learning is shared form PMRT/HSIB via the LMS safety learning network. 3. HUTH has a mandatory read requirement for all midwives and medical staff on the internal Pattie website of all SIs and HSIB cases	LMS to explore the feasibility of an LMS wide approach to completing PMRT investigations. External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.	LMS lead/Chief Nurse/HoM by 31/3/2021 LMS lead/Chief Nurse/HoM	Heads of Midwifery to assess resources/approach in relation to the development of cross-organisation PMRT investigations	The Trust currently has robust internal mechanisms for reviewing perinatal mortality. Working towards an LMS approach would be best practice and would require a review of resource.

Immediate and essential action 2: Listening to Women and Families
Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions:
Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Link to urgent clinical priorities:

(a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.
(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

What do we have in place currently to meet all requirements of IEA 2?	How will we evidence that we are meeting the requirements?	How do we know that these roles are effective?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?

1. As part of our existing SI processes, a family liaison role exists which is allocated to a named individual for each SI declared. **2.** The Trust has identified a Non-Executive Director Board Maternity Champion. **3.** The Trust has an identified Executive Director as the Maternity Safety Champion. **4.** The Trust works with two active Maternity Voice Partnerships (MVP) across Hull and the East Riding region. Hull MVP has been in operation since 2018 and in East Riding since May 2019.	1. The Trust will submit monthly data set out in '**Implementing a revised perinatal quality surveillance model' 'Appendix – 2'** via obstetric speciality governance, Family and Women's Health Group Board and the Trust Board. 2. This will evidence that co-production has taken place with service users and improvements have been made.	Annual events held over the last two years (Hull in 2019 & Goole in 2020) both used the 'whose shoes' tool to engage and listen to women who have used our services. From listening to women, both events identified opportunities for improvements in maternity service; the identified improvements included: Developed a virtual tour showcasing the maternity offer at HUTH using modern virtual reality technology – this was implemented with effect from October 2019. Implemented a monthly carousel event with key stakeholders as "a one stop shop" to enable women to receive important information such as choice of place of birth, feeding choices, immunisation, safe sleeping demonstrations as examples; these events commenced 2018	1. The Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards. 2. The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome	Trust Board to agree independent advocate role for HUTH and develop job description/banding and appropriate recruitment & selection process.	Funding for this role and a national job description /person specification	Will continue with the family liaison role from the central governance team

Immediate and essential action 3: Staff Training and Working Together
Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.

- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.

- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
(b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place

What do we have in place currently to meet all requirements of IEA 3?	What are our monitoring mechanisms?	Where will compliance with these requirements be reported?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?

1. Mandated MDT training is organised/ integrated within a planned programme; this is resourced within medical job plans and midwife establishment of Hull maternity service. The Trust will submit monthly data set out in '**Implementing a revised perinatal quality surveillance model' 'Appendix – 2'** via obstetric speciality governance, the Family and Women's Health Group Board and the Trust Board. Standard Operating Procedure for a minimum of twice daily consultant obstetrician ward rounds with supporting audit will be developed by 31/3/20212021	1. Training compliance discussed every two weeks during CNST meeting and issues escalated through to the Family and Women's Health Group Triumvirate by Head of Midwifery. 2. Head of Midwifery meets monthly with the Family and Women's Health Group Triumvirate to consider maternity safety matters. 3. Audit programme is a monthly standard agenda item on Speciality Obstetric Governance and Health Group Governance meetings.	1. Monthly Speciality and Health Group Governance meetings 2. The trust Board via perinatal quality surveillance model	None	None	None	Risk is sufficiently mitigated

Immediate and essential action 4: Managing Complex Pregnancy
There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all requirements of IEA 4?	What are our monitoring mechanisms?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

1. Every woman risk assessed as a complex pregnancy has a named consultant and the risk assessments are reviewed appropriately.	Added to the annual audit plan for 2021 and reviewed at speciality governance meetings	Speciality governance meetings held monthly and issues escalated through the Family and Women's Health Group Governance Committee.	The Trust will develop a Standard Operating procedure identifies how women are refereed into a Regional Maternal medicine centre by 31/3/2021	Clinical Lead for Obstetrics	HUTH will continue to work with clinical networks to review the service specification for Maternal medicine specialist centres.	HUTH do not currently fulfil all of the service specification to be a Maternal Medicine Centre. However we do care for very complex women with a lead specialist obstetrician with appropriate clinical competency in maternal medicine. Working with partners and the LMS – the plans is that HUTH will become a sub-regional centre. Whilst we care for the majority of complex women some are transferred to Leeds such as those women with severe cardiac complications this is less than 10 women per year.

Immediate and essential action 5: Risk Assessment Throughout Pregnancy
Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional

- Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

What do we have in place currently to meet all requirements of IEA 5?	What are our monitoring mechanisms and where are they reported?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

1. Initial risk assessment via the booking in process utilising the HUTH Guideline: ***422 – BOOKING APPOINTMENT & SUPPORTING ANTENATAL CARE GUIDELINE*****.** Using this guideline women are categorised on midwifery led or consultant led care pathway. 2. HUTH is currently compliant with four of the five elements of the SBLV2 Care Bundle. HUTH has a robust Growth Assessment Framework in place for managing high risk pregnancies.	HUTH will undertake annual audit as part of 2021 audit plan	Speciality governance meetings with escalation to the Family and Women's Health Group Clinical Governance Committee	HUTH do not currently undertake uterine artery Doppler scanning as part of the SBLV2 Care Bundle **APPENDIX-D**. The Trust is working towards full compliance by May 2021.	Clinical Lead for Obstetrics/HoM and the Clinical Support Health Group (provider of diagnostic capacity)	• Training of sonography staff • Increased scanning capacity • Increased sonography staffing • Scanning equipment • Physical space.	HUTH has a robust Growth Assessment Framework in place for managing high risk pregnancies.

Immediate and essential action 6: Monitoring Fetal Wellbeing

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

What do we have in place currently to meet all requirements of IEA 6?	How will we evidence that our leads are undertaking the role in full?	What outcomes will we use to demonstrate that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

1. HUTH has implemented a 0.40 WTE lead midwife post in line with the Saving Babies Lives Care Bundle Version Two recommendations	• Weekly maternity care reviews. • Monthly Perinatal mortality review meetings and case discussion. • LMS Safety Learning Network/shared learning	• Review of morbidity and mortality through Maternity Case Reviews/PMRT	HUTH to identify a lead obstetrician	Clinical Director for Women's Services	In order to implement this, the service would require 0.5 PA per week which will be actioned following clarification on receipt of the national guidance	HUTH has a midwifery clinical lead and will identify an obstetric lead as required. HUTH has a robust weekly maternity case review process of which themes and trends are shared via power point presentation.  MCR Themes powerpoint.pptx

Immediate and essential action 7: Informed Consent
All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care

Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care

Women's choices following a shared and informed decision-making process must be respected

Link to Maternity Safety actions:

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Link to urgent clinical priorities:

a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

What do we have in place currently to meet all requirements of IEA 7?	Where and how often do we report this?	How do we know that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

1. Patient information has been developed and is published on the Trust's maternity website pages - all key elements identified in the Chelsea and Westminster website have been included. **https://www.hey.nhs.uk/maternity/**	The information on the Trust website will be reviewed biannually	A review of HUTH maternity information will be undertaken to share best practice by 31 March 2021.	Continue the work across the LMS to develop an electronic care pathway.	LMS/HoM/CoC midwife Within national targets set out in the NHS Long term plan	An LMS wide maternity system	Appropriate information consistent with best practice examples is already available.

Section 2						
MATERNITY WORKFORCE PLANNING						
Link to Maternity safety standards: **Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard** **Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?**						
We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.						
What process have we undertaken?	**How have we assured that our plans are robust and realistic?**	**How will ensure oversight of progress against our plans going forwards?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**

Hull University Teaching Hospital maternity services undertook the Birthrate Plus® In June 2018 a recognised tool based upon an understanding of the total midwifery time required to care for women. The report identified that the maternity service required 187.18WTE midwives to provide midwifery care. The current midwifery establishment is 180.3WTE and the staffing report for midwifery proposed a role for B3 Maternity Support Workers to support midwifery staffing in community and postnatal ward settings. Currently the service in collaboration with the Local Maternity System [LMS] is working on plans to develop this role and to ensure a robust training and education package is in place with support from local colleges.	Regular reviews of established rota tools with assistant Chief Nurse	HoM 1:1 with Nurse Director and Chief Nurse	None	None	None	Risk is sufficiently mitigated

MIDWIFERY LEADERSHIP **Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in** Strengthening midwifery leadership: a manifesto for better maternity care
 Birthrate plus update January 2021.doc

NICE GUIDANCE RELATED TO MATERNITY
We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.

What process do we have in place currently?	Where and how often do we report this?	What assurance do we have that all of our guidelines are clinically appropriate?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

All of Hull University Teaching Hospital maternity guidelines follow NICE national guidance.	Guidelines are approved and ratified through the trust governance process monthly	Monitored and agreed by MDT and approved through wider MDT teams	None	NA	NA	Risk is sufficiently mitigated

Hull University Teaching Hospitals NHS Trust

Committee Summary Report to the Board

Meeting: Quality Committee

Meeting Date:	21 December 2020	**Chair:**	Julie Bolus	**Quorate (Y/N)**	**Y**

Key items discussed where actions initiated:

- Okenden Report and action update was received
- Board Assurance Framework was reviewed
- Covid backlog issues – The Plastics Service presented their issues around increased referrals (particularly 2 week waits) and capacity constraints.
- Quality Report was received. Updates relating to infection control, complaints, incidents and Covid fundamental standard reviews were included in the report.
- Research and Innovation update was received and highlighted the Covid research work that the Trust had been involved in.
- The Committee received a Safeguarding update. Work was ongoing with the Mental Health provider to ensure patients got the right care at the right place.
- A Covid Vaccination programme update was received.

Key decisions made:

- Okenden Report compliance to be presented monthly to the Committee.

Risk and assurance matters to be received by the Board:

- There had been no MRSA Bacteraemia cases this year to date.
- There had been a reduction in falls.
- The Trust had taken part in the Oxford vaccination trial.
- Deprivation of Liberty mandatory training was at 85% compliant.

- The 600% increase in 2 week wait referrals to the Plastics service .
- No harm reviews have been carried out due to capacity issues in the Plastics service.
- Okenden Report. A detailed report will be presented to the January 2021 Board meeting.

Matters to be escalated to the Board:

- Plastics Service – Harm Reviews not being carried out due to capacity issues

Hull University Teaching Hospitals NHS Trust
Minutes of the Quality Committee
Held on 21 December 2020

Present:	Mrs J Bolus	Chair – Non-Executive Director
	Mrs S Hall	Vice Chair
	Prof U Macleod	Non-Executive Director
	Mrs L Jackson	Associate Non-Executive Director
	Mrs B Geary	Chief Nurse
	Dr M Purva	Chief Medical Officer
	Mr D Corral	Chief Pharmacist
	Mrs A Green	Lead Clinical Research Therapist
	Mrs M Stern	Patient Representative
In Attendance:	Dr B Oluwadamilola	Chief Registrar
	Mr J Illingworth	R&D Manager
	Mr J Heaney	Consultant, Plastics
	Mrs L Cooper	Head of Midwifery
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	**Apologies:** Apologies were received from Mrs K Southgate Mrs Bolus introduced herself as the new Chair of the Committee.	
2	**Declarations of Interest** There were no declarations made.	
3	**Minutes** **3.1 Minutes of the meeting held 30 November 2020** Item 5.2, paragraph 1 – Mrs Geary clarified that birth partners had always been able to attend births but the visiting access for scans had been increased. Following this alteration the minutes were approved as an accurate record of the meeting.	
	3.2 Matters Arising The ENT backlogs to be discussed at the February 2021 meeting.	**MP**
	3.3 Action Tracking List The Quality Improvement Plan would be presented to the January 2021 meeting.	**KS**
	An update regarding Falls would be brought to the committee at a later date due to the lead nurse being involved in the vaccination programme.	**BG**
	3.4 Any Other Matters Arising Dr Purva and Mrs Bolus to discuss GIRFT outside of the meeting.	**MP/JB**
	Mrs Geary updated the Committee regarding the Okenden Report which highlighted poor care of mothers and babies at the Shrewsbury and Telford NHS Trust. Initially 2 families had escalated their concerns and	

this had led to more families reporting poor experiences.

A letter from NHS E/I had been sent to all Trusts highlighting urgent and immediate actions that Trusts should take. Mrs Geary advised that work had been carried out to ensure compliance against the actions and the outcomes would be discussed at the CEO/NED meeting later that day. A detailed report would be presented to the public Board in January 2021.

A Serious Incident look back exercise was being carried out and the outcomes of this would also be presented to the Board in January 2021 for assurance.

Mrs Bolus encouraged members and all staff to read the report even though it related to maternity services as the 3 key areas were, ineffective teamworking, culture of care and listening to patients and their families and this could relate to any service.

Resolved:
It was agreed that the updates would be provided at each meeting and added to the tracker.

3.5 Workplan
The Workplan was received by the Committee.

3.6 Board Assurance Framework
The Committee received the Board Assurance Framework and discussed the issues around pathology capacity and the clinical admin hubs.

Mrs Thompson clarified that BAF 3 and 6 were the main areas for the Quality Committee to review along with some aspects of BAF 4. Mr Vize had attended the Quality Committee for a deep dive into the Ophthalmology back log relating to eye injections.

BAF 6 was discussed and Mrs Bolus asked if the risk rating could be reduced due to the good work being carried out by the Research and Innovation Team. Dr Purva advised that the risk should not yet be reduced as there was more work to do. A lot of work had been carried out that was Covid related but the risk spanned beyond the Covid work.

Resolved:
The Committee received and accepted the report.

4.1 Covid – Plastics Update
Dr Bamigbade introduced the report which updated the patient priority levels from April 2020 and the new triggers and changes to priority groups.

Dr Bamigbade advised that any priority 2 patient should be seen within a 4 week period but the average wait at the moment was 19.5 weeks. This should trigger a harm review but due to the amount of breaches and limited capacity the harm reviews have not been carried out.

There were 69.9% of priority 3 patients waiting longer than the usual 3 months and 1043 priority 4 patients that had been waiting longer than a year. Theatre capacity had been reduced due to Covid and staff had

been redeployed to other areas. Mr Haeney advised that there was limited time for admin work currently.

There had been no formal complaints to the service but patients had expressed their dissatisfaction.

Work was ongoing to carry out procedures in the independent sector and run clinics. The specialist ward at Castle Hill Hospital had been taken over by Covid patients and although breast cancer cases had been treated, breast reconstruction work was not a priority at the moment.

The Spire were carrying out work on behalf of the Trust but were operating on 8 patients a day instead of the 12 that the Trust would complete.

Dr Purva advised that there were issues with the CCGs and Primary Care as the Trust had asked that any suspect cancer referrals have an image attached to assist the Trust and ensure patients where on the right pathway. This had not yet been agreed although this would help to prioritise patients more effectively. Mr Haeney advised that 2 week wait referrals had increased by 600% in the last few years which was overwhelming the system.

Mr Hall expressed his concern and stated that the issues should be raised at the Board. He was keen to understand the impacts of no harm reviews being undertaken and reclassifying patients. Dr Purva advised that the quality impacts would emerge and a retrospective review undertaken.

Mrs Bolus asked if quality impact assessments had been carried out relating to the re-deployed workforce and Mrs Geary advised that Gold Command would review this area.

Mrs Jackson commended the team for the great work they were doing but added that she did not feel assured that patients were safe due to the capacity issues and volume of referrals. Dr Purva advised that everything was being done to keep patients safe and the service knew what the problems were and worked tirelessly to keep on top of the numbers.

Resolved:
The Committee received the report and agreed to escalate the issues around the CCGs agreeing new pathways.

5.1 Quality Report
Mrs Geary reported that there had been no MRSA Bacteraemia cases reported and 2 cases of C Difficile in the last month.

There had been 4 Covid outbreaks in the hospital. H90 and H9 were due to the wards having frail, elderly and dementia patients and had seen patient to patient transmission. There had been an outbreak of D and V in H70 and Pulmonary TB had been found on a patient admitted via ED.

Mrs Geary advised that there had been an increase in reporting hospital onset Covid 19 and this was mainly due to the increase in swabbing and was impacting patient flow. All Covid 19 deaths would be subject to

structured judgement reviews and monitored through the Mortality Committee.

Dr Purva added that the Mortality Committee would be reviewing the spike in deaths in June as well as the recent spikes in November and December 2020. The Medical Examiners were now in place and were also reviewing any lessons learned to help with the 3rd wave.

Mrs Geary advised that the lateral flow testing had been rolled out which was causing some short term sickness issues but these numbers were low compared to other Trusts.

There had been 7 Serious Incidents reported in month and there were 34 open past the expected timescales. MP advised that this data should be presented in a SPC chart, which would show the variances. There had been a significant decrease in falls in month but this did not change the quality improvement work being carried out. Mr Hall suggested that this information be added to an SPC chart also.

Procedures were in place to avoid Covid patients suffering pressure damage due to proning and devices, some of the damage was unavoidable.

Complaints were now RAG rated within the Quality Report and work was ongoing to improve performance. This was proving difficult due to not being able to have face to face meetings with patients and families.

Mrs Geary advised that the fundamental standard audits were being carried out by specialist teams as a quality review process of the wards but had been slimmed down and new Covid standards added. The results showed that there was good assurance around infection prevention and knowledge of Covid procedures. Mrs Bolus highlighted worsening positions around ID badges being worn and patients not knowing the named nurses. Mrs Geary advised that work was ongoing to address this and had introduced yellow badges for all nursing staff.

Resolved:
The Committee received and accepted the report.

5.2 Research and Innovation Update
Mr Illingworth presented the report and advised that the Trust was ranked 3rd in the Country as Yorkshire and the Humber had over 2,300 participants enrolled into National Institute for Health Research (NIHR) Urgent Public Health (UPH) studies looking into treatments for COVID-19.

HUTH will continue to provide equitable access for patients and staff to both Urgent Public Health Research and non-COVID-19 research where it is possible and safe to do so.

HUTH is working with colleagues from Yorkshire and Humber CRN on a strategic project to help manage misinformation on COVID-19 research, specifically the COVID-19 vaccine, within local communities ensuring that those of Black Asian and Minority Ethnic groups are able to make informed decisions in a safe environment.

The MHRA approval of the Pfizer/Biontech vaccine and national rollout programme had commenced and the research team will begin a co-ordinating unblinding of any trial participants who are called up to receive the Pfizer vaccine over the next few weeks. HUTH is working with the Oxford team to work through the logistics.

Vaccination work would carry on in 2021 with regards to vaccinating in pregnancy, Mr Illingworth advised that he would be working with Lorraine Cooper the new Head of Midwifery.

The Research and Innovation Team was working to the National agenda to adjust its strategy in line with the recovery programme.

Mrs Bolus suggested that she met with Mr Illingworth before his next update in March 2021 with a view to reviewing BAF 6. She thanked him and his team for their resilience and hard work during the pandemic. **JI/JB**

Prof Macleod suggested that she, Mr Illingworth and Dr Purva also met to ensure the Academic plan was aligned with the Trust Strategy. **JI/UM/MP**

Resolved:
The Committee received and accepted the report.

5.3 Safeguarding Update
Mrs Geary presented the report and advised that there had been no changes to the Safeguarding agenda due to the pandemic.

The regulatory notice received regarding the Child Sexual Assault Assessment Service had been addressed and the Trust was waiting for the report back following the introduction of new forensic cleaning products.

HUTH remain compliant at over 80% across levels 1, 2 and level 4 of safeguarding children training.

Mr Hall asked about section 36 notices and Mrs Geary advised that work is ongoing with the mental health provider to ensure that patients with mental health issues got the right care in the right place as the Trust did not have enough suites for all patients.

Mrs Geary advised that the Trust required a Learning Disabilities nurse dedicated to the organisation and work was ongoing with the Safeguarding Lead and Humber Mental Health NHS Foundation Trust to review what this role would look like.

A new Safeguarding dashboard had been presented with the report and the Committee were asked to review it. The Committee were happy to adopt the dashboard and would review it in 3 months' time to ensure it was providing assurance.

Resolved:
The Committee received and accepted the report.

6 Any Other Business

6.1 Opertional Quality Committee

Dr Purva advised that the Committee had been stood down due to operational pressures. The Mortality and Morbidity Committee had continued to meet.

6.2 Ethics Committee

Mr Hall presented the Ethics Committee summary to the Committee.

7 Chairman's summary to the Board

Mrs Bolus highlighted key areas to be summarised to the Board:

Opportunities

The non-Covid research strategy to be adjusted in line with the National agenda and recovery of services.

Successes

There had been no MRSA Bacteraemia cases this year to date.
There had been a reduction in falls.
The Trust had taken part in the Oxford vaccination trial.
Deprivation of Liberty mandatory training was at 85% compliant.

Risks

The 600% increase in 2 week wait referrals to the Plastics service .
GP pathways not agreed with the CCG and Trust.
No harm reviews have been carried out due to capacity issues.
Okenden Report. A detailed report will be presented to the January 2021 Board meeting.

Mrs Geary advised that the Covid vaccination hub work was continuing and a lady (83) had received the first vaccination. She told the Team that she saw it as a lottery win and that she could finally go for a walk, hug her grandchildren and see her great-grandchildren. Mrs Geary advised that the vaccination roll out was continuing with 975 vaccinations booked for next week.

She thanked the work that doctors, nurses and the pharmacists had put into the programme, which was having a brilliant impact on patients. Mrs Bolus added her thanks on behalf of the Committee.

Mrs Bolus asked what was working well for the Committee and Mrs Jackson stated that the deep dives into services was informative and the review of the BAF was thorough.

Mrs Stern spoke of her recent experience and thanked the Plastics team for explaining the issues surrounding the service.

Mr Hall added that it was good to involve services and have other staff present at the Committee. He added that the time management of the Committee was good.

Mrs Bolus wished Committee members a Merry Christmas.

8 Date and time of the next meeting:
Monday 25 January 2020, 10am – 12pm, via Webex.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

TRUST BOARD

12 January 2021

Title:	Covid Preparedness Report	
Responsible Director:	Michelle Kemp, Director of Strategy and Planning	
Author:	Michelle Kemp, Director of Strategy and Planning	
Purpose:	The purpose of this document to provide the Trust Board with an update on the organisation's ongoing response to the Covid 19 pandemic.	
BAF Risk:		
Strategic Goals:	Honest, caring and accountable culture	
	Valued, skilled and sufficient staff	X
	High quality care	X
	Great local services	X
	Great specialist services	X
	Partnership and integrated services	X
	Financial sustainability	
Key Summary of Issues:	• The Trust has passed through wave 2 of the pandemic and has entered wave 3, demonstrated by significant increases in demand for inpatient care and treatment for patients with covid illness. • Efforts to recover the impact of the first and second waves of the pandemic on elective activity have been impacted by the third wave of the pandemic.	
Recommendation	That the Trust Board notes the content of this paper and indicates whether any further assurance is required.	

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

TRUST BOARD

Update on the Trust's response to the covid 19 pandemic

1 Purpose

This report provides an update on the Trust's ongoing response to the Covid 19 pandemic.

2 Update on Covid 19 activity in the Trust as at 6 January 2021

The Trust is now experiencing a third wave of Covid 19 activity and in order to manage this, a proportion of the general, acute and critical care inpatient bed bases continues to be allocated for the care of patients with covid illness in line with a defined but flexible surge response plan.

The first period of national lockdown started on 23 March 2020 and ended on 15 May 2020. The peak experienced by the Trust as part of the first wave of the pandemic occurred on 21 April 2020, with 110 confirmed Covid 19 inpatient cases. Critical care case numbers peaked 11 days later on 2 May with 20 confirmed cases.

National lockdown period 2 started on 5th November and ended on 3 December 2020. The second wave peak occurred on 16 November 2020, with Covid 19 inpatient numbers reaching 183. Critical care inpatient numbers reached their wave 2 peak 8 days later at 20 patients on 24 November 2020.

At the end of the second period of national lockdown on 3 December 2020, the Trust had 152 confirmed inpatient cases of Covid-19, 15 of which were in critical care.

As at 6 January 2021, the Trust has entered a third wave and is seeing escalating case volumes of patients with covid illness, with 214 cases, 13 of which are in critical care and a further 13 patients receiving higher acuity respiratory care. A third national lockdown commenced at midnight on 5 January 2021 and this is expected to remain in place until mid-February 2021.

The delayed peaks for critical care seen in wave 1 and wave 2 are in line with expected disease profile and length of stay for patients with severe covid illness.

3 Command and control arrangements

As reported last month, The Trust continues to operate frequent Gold Command meetings (currently 3 times per week), which are chaired by a member of the Executive Team.

These are supported by 4 Silver tactical meetings per week and 1 Elective Recovery Group meeting per week which is focused on maximising elective capacity through a variety of sources, including the NHS national treasury funded contract for independent sector capacity.

The Trust continues to produce and circulate two Covid dashboards per day that report key operational and escalation indicators derived from a range of internal and external sources, including public health, regional critical care network, system level information and joint regional operations information via the LRF network. We continue to monitor a defined set of elective waiting time indicators, specifically for our highest priority elective patients.

4 Covid Response plan update

4.1 The revised surge plan outlined in the November report continues to be regularly updated and was used by the command teams to good effect during December and the Christmas and New Year period. Key aspects of the surge plan and associated command structure that have worked well to date are:

- Strong, highly cohesive and organised command structure flexes to operate across 7 days per week as required.
- Outstanding clinical leadership by our senior nursing, medical and AHP teams.
- Flexible use of the surge plan has enabled swift adaptation to changing demand pressures and emerging circumstances, e.g. case volumes, competing capacity pressures, oxygen demand management, workforce factors.
- Engagement with system partners and NHSEI team is well established and generally effective.
- ICC/Emergency Planning support arrangements are working well.
- Vaccination programme running as a separate work stream alongside the command structure is working well, with regular updates provided via Silver and Gold command groups.
- Including winter and EU transition within Covid command structure has worked well and supported co-ordinated decision making.
- Regular, high quality and effective communications with all audiences.
- The structure has coped well with command changes at senior level.

Entering wave 3 has further impaired the Trust's ability to progress with elective recovery at the intended pace due to conversion of surgical wards to covid wards on the Castle Hill site and associated workforce redeployments.

The Trust will continue to maintain a surge plan ready to respond to any further peak in Covid 19 admissions as wave 3 phase of the pandemic progresses.

4.2 Staff deployment plan update.
The workforce plan for all key staff groups, which aligns to the revised bed configuration model continues to work well and has been able to withstand the impact of increases in staff absence, which at the time of this report is running at circa 10% total absence, with 4.5% attributed to covid related sickness absence. The deployment of each stage of the surge plan and associated staff redeployment plan continues to be led by Silver Command with oversight by Gold Command, working with a common aim of ensuring a proactive approach to preparation for capacity changes.

5 The Covid Vaccination Programme

The Trust is now fully operating the Hub for the Humber, Coast and Vale area for the Covid mass vaccination programme. The Chief Nursing Officer continues to lead this work. Two vaccines have now been approved for use in the UK and circa 4k people have received vaccines in the first few weeks of operation of the HCV Hub.

6 Recommendation

That the Trust Board notes the content of the paper and indicates whether any further assurance is required.

Michelle Kemp
Director of Strategy and Planning

Hull University Teaching Hospitals NHS Trust

Trust Board

12 January 2021

Title:	Our People
Responsible Director:	Simon Nearney - Director of Workforce and Organisational Development
Author:	Simon Nearney - Director of Workforce and Organisational Development

Purpose:	The purpose of the report is to provide the Board with an overview of the key people issues.	
BAF Risk:	Goal 1 – Organisational Culture, Staff Engagement Goal 2 – Valued, skilled and sufficient staff	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great clinical services	✓
	Partnership and integrated services	✓
	Research and Innovation	✓
	Financial sustainability	✓
Key Summary of Issues:	The Trust staff vacancy rate is currently 3.5%. Staff absence overall is currently 9.99% which includes Covid-19 related, other absences and maternity leave. The Trust flu programme has continued at pace. 7,300 staff have been vaccinated and staff wellbeing and support arrangements continue to work well. Asymptomatic staff testing (Lateral Flow) is in place for all patient facing staff and the Covid-19 vaccination programme commenced in December 2020.	

Recommendation:	The Trust Board is requested to note the content of the report and provide any feedback.

Hull University Teaching Hospitals NHS Trust

Trust Board

12 January 2021

Our People

1. Purpose

The purpose of the report is to provide the Board with an overview of the key people issues.

2. Background

The Trust went into the third national lockdown on 6th January which was very much needed to stop the spread of the virus and protect NHS services. Since the last Board meeting on the 8th December our Covid-19 inpatient numbers have increased by 77 from 143 to 220. The Trust has had 100% increase in Covid-19 patients since the peak in the first wave. The Trust continues to review and implement further phases of its surge plan and Command structures are managing operations day to day. Some elective activity has been stood down and staff continue to be redeployed to support medical wards, ICU and ED. The Trust has been battling the pandemic for over 10 months and this is having an impact upon our staff. The national lockdown will be reviewed mid-February.

3. Key Issues

Staff Absence

The total staff absence for the financial year 2019-20 was 3.67%. This is excluding Covid-19 absence. The Trust attendance target for attendance was 96.1% (sickness not to be greater than 3.9%).

The Trust currently has 456 staff absent due to Covid-19 which is 4.51% of the workforce. Total absence including maternity leave and all other reasons for absence is 9.99%. This is a slight reduction from 10.52% as at the last Board meeting in December.

Staff absence usually runs at 3.6%, so the Trust is well above its normal absence levels which means staffing is a significant risk to the provision of services. In addition, with the Prime Minister announcing those people who are Clinically Extremely Vulnerable must shield again this will affect approximately 100 of our staff. Our risk assessment process has been updated accordingly and circulated to all managers and staff.

4. Staff Testing

PCR Test

The Trust continues to test staff and family members for Covid-19 via a drive through facility which has been in operation since April 2020. Between April-December, we have tested 10206 HUTH staff or family members, 1411 (13.8%) of which were positive.

During December 1515 HUTH staff or family members were tested. 403 HUTH staff or family members tested positive. The positivity rate for December was 26.6% (This includes staff referred to the drive through as a result of a positive lateral flow test). The positivity rate for November was 15%.

The Trust also tests a small number of staff from CHCP, Yorkshire Ambulance Service, Humber FT and others, which are additional to the figures above.

Asymptomatic Staff Test (Lateral Flow)

Patient facing staff are being asked to test themselves for Covid-19 twice weekly effective from Monday 30th November 2020. This will enable the Trust to identify staff who have no symptoms,

but who might be positive and should be self-isolating. Staff have received 25 test kits each, enough to last 12 weeks. Staff test themselves the night before their shift, allowing 30 minutes for the result. Approximately 7,000 test kits have been distributed to staff and since implementation the Trust has received 12846 test results back with 138 positive results (approx. 1%). These positive staff have all been confirmed via a PCR test and are included in the numbers stated above.

Test and Trace
The NHS Test and Trace programme launched on Friday 5th June 2020. If a staff member tests positive for Covid-19, the Trust is responsible for ensuring all work related 'contacts' are identified and those staff members instructed to self-isolate for 14 days. The Trust Test and Trace operation is managed through the nursing team attached to the ESC Helpdesk. To date the Trust has requested 762 staff to self-isolate as a result of a 'contact' within their workplace. In August the figure was 8, which increased to 32 in September, 192 in October, 236 in November and 137 in December.

5. Staff Vacancies
The Trusts overall vacancy position as at 30th November 2020 is as follows:

Staff Group	Establishment WTE	Staff in Post WTE	Temp Workforce WTE	Vacancies WTE	Vacancy Rate %
Additional Clinical Services	1457.5	1361.8	48.8	46.9	3.2%
Add Prof Scientific and Technical	351.0	294.4	0.0	56.6	16.1%
Administrative and Clerical Staff	1557.9	1560.8	5.0	-7.9	0.0%
Allied Health Professionals	482.2	457.5	14.9	9.8	2.0%
Estates and Ancillary	574.3	536.3	4.5	33.5	5.8%
Healthcare Scientists	303.2	294.1	8.8	0.3	0.1%
Medical & Dental - Consultant	488.5	443.2	28.8	16.5	3.4%
Medical & Dental - SAS	65.7	53.6	0.0	12.1	18.4%
Medical & Dental – Trainee Grades	665.6	657.1	6.9	1.6	0.2%
Nursing and Midwifery Registered	2387.6	2239.1	28.4	120.1	5.0%
Trust Total	8333.5	7897.9	146.1	289.5	3.5%

Overall the Trust vacancy position is 3.5%. The Consultant vacancy rate is 3.4%. Whilst our vacancy situation remains in a healthy position the Trusts recruitment plans during this financial year have been somewhat interrupted, but recruitment and retention remains a key priority.

The vacancy rate for Registered Nursing and Midwifery is currently 5% across the organisation.

There are currently 59 Trainee Nurse Associates (TNA) employed by the Trust in a range of specialities. The Trust has successfully trained and developed 28 Registered Nurse Associates over the past 2 years who are now part of the registered nursing workforce. 16 of the 2019 cohort are currently completing their programme, with a plan for them to obtain their PIN in March 2021. The Trust is currently commencing a further recruitment campaign for a further cohort of 25 TNA`s to commence their programme in May 2021.

The Trust has 33 Student Nurse Apprentices in training. In addition, the Trust has 21 Health Care Support Worker apprentices. In partnership with Hull College and the University of Hull, the Trust has successfully recruited a further 6 Health Care Support Worker apprentices who will commence their programme in January 2021.

From an international nurse perspective, prior to Covid-19 the Trust was pursuing a further 25 international nurses, 11 of this cohort have now successfully passed their OSCE and are included in the 114 international nurses within the establishments; the remaining 14 are due to take their OSCE on the 6th January 2021. In order to support the Trusts winter plan and surge capacity for Covid-19 funding was approved to recruit a further 23 international nurses (21 for Medicine and 2 for Ophthalmology theatres) these individuals have now arrived and commenced employment with the Trust and are due to sit their OSCE exams at the beginning of February 2021. In addition, 10 theatre nurses have been recruited to support and improve the current 52 week position across surgical specialities, these are due to travel on 25th January and commence employment. The Trust has confirmed the NMC test centres are currently remaining in operation and there are no plans to stop travel at present from the Philippines.

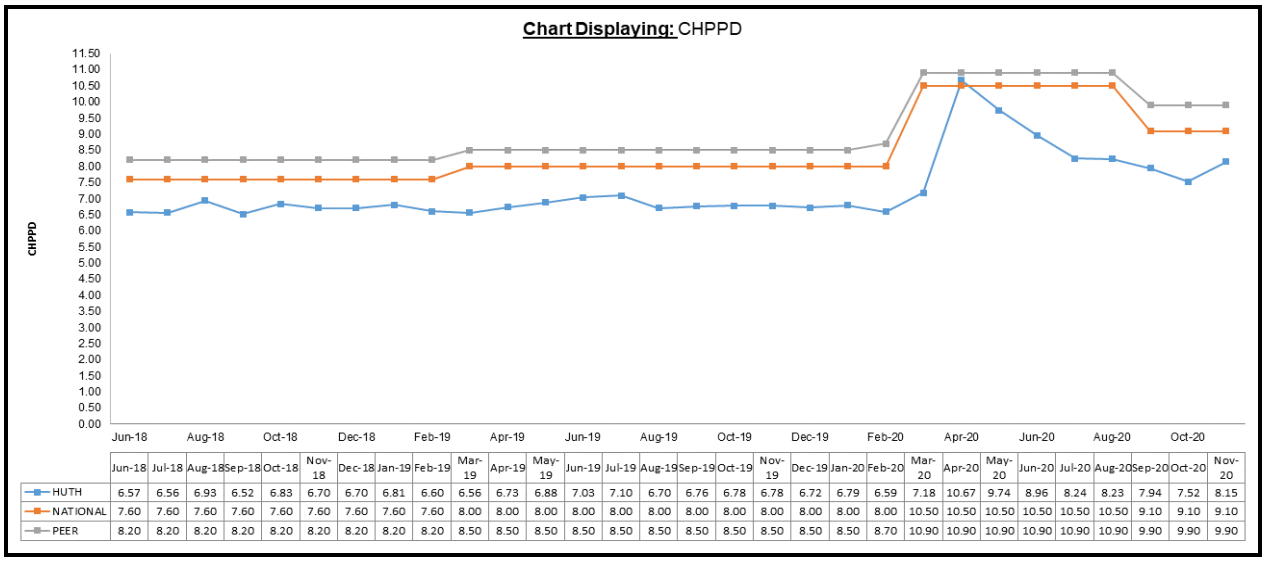
In response to the financial support offered by NHSI/E in relation to recruiting additional international nurses, the Trust has been successful in securing the funding for an additional 45 international nurses, who will commencement employment with the Trust throughout March and April 2021.

The University of Hull held a virtual open event on the 15th December 2020, which was extremely successful. The Trust attended and discussed careers in HUTH with over 80 students. As a result of this day HUTH has signed up 115 students for interview during January. The interviews will be carried out virtually during January 2021 with the Practice Development Matrons (PDM), clinical nurse educators and nursing teams, supported by our Education and Training team. Further events are being held this month to attract more students from universities such as Lincoln, Leeds, York and Nottingham.

6. Care Hours per Patient Days

Care Hours Per Patient Day (CHPPD)

As illustrated below the CHPPD for November 2020 is 8.15, this has increased from 7.52 from the previous month. Initial analysis indicates that this is related to the commencement of all new starters with the Trust throughout November 2020.



	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
HUTH	6.57	6.56	6.93	6.52	6.83	6.70	6.70	6.81	6.60	6.56	6.73	6.88	7.03	7.10	6.70	6.76	6.78	6.78	6.72	6.79	6.59	7.18	10.67	9.74	8.96	8.24	8.23	7.94	7.52	8.15
NATIONAL	7.60	7.60	7.60	7.60	7.60	7.60	7.60	7.60	7.60	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	10.50	10.50	10.50	10.50	10.50	10.50	9.10	9.10	9.10
PEER	8.20	8.20	8.20	8.20	8.20	8.20	8.20	8.20	8.20	8.50	8.50	8.50	8.50	8.50	8.50	8.50	8.50	8.50	8.50	8.50	8.70	10.90	10.90	10.90	10.90	10.90	10.90	9.90	9.90	9.90

7. Staff Flu Campaign
The Trust has a Board agreed action plan which commenced in October 2020. Despite some difficulties in vaccines being delivered, the Trusts Occupational Health Department and volunteer vaccinators have worked tirelessly to ensure staff are vaccinated. As at 31st December, the Trust has vaccinated 7,300 staff of which 86% are frontline healthcare staff. A number of the volunteer vaccinators that have been trained by the Occupational Health Team have the transferrable skills required for them to be ready to participate in the Covid-19 vaccination programme.

8. Covid-19 Vaccination programme.
HUTH has been designated the Lead Agency to deliver the ICS Covid-19 vaccination programme. Led by Beverley Geary, Chief Nurse a population and health and care staff vaccine programme and plan has been developed and is being implemented at pace.

9. National Staff Survey
The National Staff Survey was launched in September to understand the current levels of staff engagement as well as other key indicators. It closed on 27th November 2020. 3,384 staff (38%) completed the survey. Last year we completed 37%. The national average response rate was 45%. We are below the national average, but our response rate compares favourably with other organisations in Humber Coast and Vale.

Our results are expected in the next few weeks.

10. Staff Support Arrangements
The Staff Psychosocial Support service which is a partnership of our Psychological Services, Pastoral and Spiritual Care, Occupational Health and Organisational Development teams continues to support staff at whatever level of intervention is required. Health and wellbeing of our staff throughout the pandemic has and will always be a priority. Additional services available this time has been personal coaching alongside virtual drop in sessions and the creation of staff support groups for those affected by Covid-19. We are also in the process of recruiting a clinical psychologist specifically to support staff on a permanent basis.

The Trust has also received funding to implement Schwartz Round in their virtual shorter format called “Team Time”. This will initially be for 6 months, with the option for us to extend and become a fully accredited Schwartz Round organisation. The steering group is being convened and the Executive sponsor is Chief Nurse, Beverley Geary. Facilitators will be training during December with the first Team Time session expected to take place in January 2021.

In addition the Trust has reintroduced free meals and refreshments for staff and provide accommodation for staff who have to work late and travel or need to be away from their household to continue in their role. The Trust continues to provide free parking. The Trust also has childcare provision on standby if our staff require it. However, Government advice is that children of ‘critical workers’ should continue to attend school. This will be kept under constant review.

11. Education and Development
The popularity of and diversity of subjects added to our virtual classroom (Big Blue Button) continues to grow with 850 individual members of staffing having accessed at least one session.

We have formed a partnership with HDigital to service this further so more staff can access sessions (infrastructure, IT equipment) and will partner on delivering the outcome of a joint training needs analysis which makes sure staff have the kit and skills to access and deliver.

Further to this Education have installed 10 fully kitted out sound proof booths at CHH and HRI to enable key education topics to be delivered (big Blue Button) by subject specialist who just simply don’t have the kit to do so without this investment. This has an added benefit of being able to deliver not only with the latest kit but in a supportive environment with expertise on hand. An example of this is the CNE team delivering essential clinical skills training that otherwise would not be possible.

Education continue to invest in and introduce new and innovative resources for essential training to continue under the present circumstance. A further example of this is the introduction of Greenlight, which is a complimentary plug in to our existing learning management system and partners the Big Blue Button. Greenlight enables us to provide education services to other Care partners, engage with schools and colleges and universities as well as external delegates. It is anticipated that Greenlight and the Big Blue Button will also be a central and pivotal component of engagement for recruiting healthcare students to the Trust.

12. Communication and engagement

The HUTH communications team is leading on communications for the vaccination programme across Humber Coast and Vale. A weekly stakeholder briefing for all HC&V staff and stakeholders is being prepared along with a rolling media campaign for the vaccine roll out. Engagement sessions with partners are being held on a weekly basis.

The Exec team hold are holding virtual weekly Exec Friday Forum meetings for all staff to log in and hear key HUTH updates. One session saw 234 staff sign in. Staff can ask questions via the online chat function.

Twice weekly Director of Workforce briefings are continuing to go out to all HUTH staff.

13. Conclusion

During the pandemic the Trust has focussed on the health and wellbeing of our people as well as recruitment plans and our equality and inclusion programme. The Trust has tried to ensure 'staff experience' is also maintained which has been a challenge considering the pressure the Trust has been under and staff being redeployed to ensure patients are safe and cared for as best as possible. The Trust has achieved its highest ever rate for staff flu vaccinations and now our focus is on the Covid-19 vaccine and ensuring our staff receive the vaccination as soon as possible. Our staff continue to work incredibly hard and show their dedication to our patients and their families on a daily basis.

14. Recommendations

The Trust Board is requested to note the content of the report and provide any feedback.

Officer to contact:

Simon Nearney
Director of Workforce and OD

TRUST BOARD: TUESDAY 12th JANUARY 2021

FINANCE UPDATE – MONTH 8

1. Purpose of Paper

To inform the Trust Board on the month 8 reported financial position and update on the level of expenditure committed in managing Covid19.

2. Background

NHSEI have split financial reporting for 2020/21 into 2 periods. The first 6 months was supported by a 'true-up' system to enable Trusts to claim additional income to support costs and report a break-even position. For the second 6 months, Trusts have been set a fixed financial envelope to work within.

The Trust reported a break-even position for the first 6 months with 'true-up' income of £10.6m. All of this income has been received – with the final receipt made mid-December.

For the second six months the Trust submitted a plan with a deficit of £6.0m based on shortfalls on other income (eg Car parking, catering, private patients) and the expected need to account for an annual leave provision at year end due to the potential difficulty of staff being take to take all their leave in-year due to Covid19 pressures. The Trust has had no official feedback on the submitted plan.

3. Month 8 Reported Position

At month 8, the Trust has reported a deficit of £0.9m, which is £0.15m better than plan.

Income in several areas has fallen even further than the planned shortfall. Injury Recovery Scheme (£0.13m), Catering income (£0.08m) and car parking (£0.02m) are all below the reduced planned levels due to the impact of the second wave of Covid19. Offsetting this however, the Trust has received additional income from Health Education England, reversing previous shortfalls (£0.3m).

In total, other income is £0.15m above the planned level and is the driver for the reported performance better than plan.

In month 8 the Trust spent £1.1m in dealing with Covid19, bringing the total spend for the 2 months (months 7 and 8) to £1.8m. This includes £0.3m on testing. The reduction in levels of spend from the first 6 months reflects the move to national procurement of PPE and the return of aspirant doctors and nurses to educational institutions or into substantive roles. However spend was higher in month 8 compared to month 7 as the 2nd wave of Covid19 started to have an impact. This included opening the winter ward a month early and continued backfill costs to deal with covering staff sickness. Costs of covering agreed additional capacity and medical rotas are expected to increase further from month 9 but these will still be within the overall funding envelope the Trust has been given specifically to cover the Covid19 pressures.

The Trust is currently working up the costs required to implement the vaccination programme across the Trust and the wider ICS. The costs of this will be fully funded through NHSEI based on the principles of actual, reasonable, incremental costs as incurred and on the basis of prior agreement for exceptional costs exceeding the national modelling. Funding will flow monthly, in arrears and as lead provider for the ICS, the contractual documentation is being developed and agreed with NHSEI, as well as the associated sub-contracts with other providers.

The Trust is currently forecasting a deficit of £5.5m for the six month period to March 2021, which is £0.5m better than plan due to higher levels of non-patient care income, predominantly from Health Education England. Further work is ongoing to review the overall forecasts at Trust and ICS level to inform the more detailed reporting required at month 9.

4. Capital

The reported capital position at month 8 shows gross capital expenditure of £18.83m. The main areas of expenditure relate to Capital COVID (£2.6m), Backlog maintenance (£1.5m); IM&T (£1.6m); Expansion of Acute bed base (£2.2m) and Robotic Scheme (£1.5m).

The forecast position for capital expenditure (incl PFI/IFRIC12 impact) is £59.8m; this includes assumptions on the Trust receiving PDC allocations relating to Backlog Maintenance (£4.9m); Capital Covid (£2.6m); ED UEC (£4.3m); Critical Infrastructure (£5.9m); ICU (£3m); Radiotherapy CTs (£1.2m); Adopt & Adapt (£1.4m) and Oxygen (£0.4m). In addition, the Trust is also anticipating additional PDC relating to Digital Aspirant (£2.5m). We are confident these allocations will be spent by 31 March 2020 and the forecast reflects this.

As previously reported, the Trust has had approval of the Urgent & Emergency care Business Case (£10.5m), however due to delays in approval and to ensure an accurate forecast is included, since M6 the Trust has reported slippage of £6m into 21/22. In addition, the Trust has reported slippage of £2m associated with the Brocklehurst scheme and the Digestive Suite scheme. The slippage is expected to be granted and the cash will be moved into next year, with no loss of spending power.

The Trust has also recently revised the year-end forecast depreciation figures resulting in an increase of depreciation of £0.5m. The Trust will also report £2.1m lower CDEL against plan as a result of changes agreed at ICS level and this is also reflected in the Trust's forecast position.

5. Cash

At month 8, the Trust's liquidity position remains healthy with a cash balance of £84.8m, which is higher than last month. In the main, the increase in month is driven by the £8.5m payment from Heath Education England, based on the education contract for the remainder of the year. The forecast cash position continues to assume that there are 12 block payments in the year and therefore that the current cash gain from an additional block payment is neutralised by year-end. Indicative forecasts suggest a cash balance of circa £28m by year- end but this is heavily dependent on the timings of payments associated with the capital programme and the activity levels/Covid admissions for the remainder of the year.

6. Summary

The Trust has reported a deficit of £0.9m at month 8, which is £0.15m better than the submitted plan. It is forecasting a deficit of £5.5m, which is £0.5m better than the financial plan for the 6-month period to March 21.

Stephen Evans
Deputy Director of Finance
January 2021

Hull University Teaching Hospitals NHS Trust

Trust Board

12 January 2021

Title:	Proposal to form Contractual Joint Venture between HUTH and YTHFT for the Provision of Pathology Services
Responsible Director:	Lee Bond
Author:	Dave Oglesby

Purpose:	The board is requested to approve the proposal to form a pathology network incorporating the laboratory services at Hull University Teaching Hospitals and York Teaching Hospitals Foundation Trust. The attached business case proposes the creation of this network through a contractual joint venture. The case and the recommendations within it have been approved by the Pathology Collaboration Steering group that has overseen the programme.	
BAF Risk:		
Strategic Goals:	Honest, caring and accountable culture	x
	Valued, skilled and sufficient staff	x
	High quality care	x
	Great clinical services	x
	Partnership and integrated services	x
	Research and Innovation	x
	Financial sustainability	x
Summary Key of Issues:	Creation of the Hull York Pathology Service through a contractual joint venture that addresses the mandate from NHSI in for the Establishment and Implementation of Pathology Networks Across England, September 2017. The proposal makes a number of recommendations. A recommended configuration of laboratory services that provide long term sustainable solution to providing pathology services in the challenging NHS environment and can deliver service efficiencies and cash savings over the 10 years. The case recommends the host for the new network to be YTHFT and that the newly formed network is overseen by a joint oversight committee formed from executive leads from both partner trusts. That the new service undergoes a programme of development activities over the next three years to reach the target operating model.	

Recommendation:	The board is requested to approve the attached business case and recommendations from the Pathology Collaboration Steering Board.

Hull University Teaching Hospitals NHS Trust

York Teaching Hospital NHS Foundation Trust

Hull and York

Pathology Collaboration

Proposal to form Contractual Joint Venture between HUTH and YTHFT for the Provision of Pathology Services

Contents

EXECUTIVE SUMMARY

Introduction

Pathology test results contribute to clinical decision-making in an estimated 70% of patient pathways. Pathology services support diagnoses and clinical decision making in all care settings including primary care, outpatient consultations, unplanned and planned inpatient care.

There have been numerous reports on pathology in the last 20 years including Lord Carter's Independent Review of NHS Pathology Services in England (2008) and Lord Carter's review of unwarranted variation in the operational performance and productivity in English Acute Trusts (2016). All point strongly towards the consolidation of pathology services 'as a means of improving both service quality and cost effectiveness'.

In September 2017 the National Pathology Implementation and Optimisation Delivery Group signalled to all acute hospital trusts in England that they would need to change how they work and collaborate to drive out unwarranted variation in pathology services. In September 2018, NHSI published an update to their 2017 proposal (*'Pathology – State of the Nation'*) in which they recognised the potential for a new pathology network made up from the service at Hull University Teaching Hospitals NHS Trust and York Teaching Hospitals NHS Foundation Trust. (Referred to as North 7 Hull York Pathology Services (HYPS).

This business case is based on the programme of work undertaken by the Hull York pathology collaboration group prior to the outbreak of the COVID pandemic.

Local Context

Humber Coast and Vale Health and Care Integrated Care System (HCV ICS)

In July 2018 HUTH and YTH Trusts stated their intention to collaborate on the creation of a pathology service network that offers laboratory services for the HCV region north of the Humber (the Hull York Pathology Collaboration).

The Pathology Collaboration programme began in September 2018 to develop the future plan for delivering pathology services for Hull and York acute hospital trusts and associated primary and social care organisations in the region.

The guiding goals for the pathology collaborative were to develop a plan that will support the delivery of the ICS's vision by:

- Ensuring that the region has an innovative and sustainable pathology service capable of adapting to the changing needs of clinicians and patients.
- Supporting clinicians and clinical teams to deliver integrated and patient-centred care.
- Attracting, developing and retaining the skills needed to deliver a modern pathology service, and utilising these skills efficiently and effectively across the region.

- Investing in the skills and technology needed to deliver modern diagnostics, through pooling resources and undertaking testing at scale where appropriate.
- Providing an efficient, effective and high quality pathology service which will contribute to delivery of financial efficiencies across the HCV ICS through direct pathology savings, facilitating savings elsewhere in the health and social care system and through supporting integrated pathways across the acute, community and primary care settings.

The strategic case for the collaboration and future network was agreed by HUTH and YTHFT boards in October 2018.

The Case for Change

Growing demand and increased test complexity

Pathology demand in Hull and York is projected to grow across all specialties and sources (hospital, GP and community). Sample growth is projected to increase from current levels by 6% by 2022/23, driven mostly by demographic growth. Test growth is predicted to increase from current levels by 15% by 2022/23, driven by greater testing per sample (higher sample to test ratio in ageing population).

The financial impact of this increased demand is a 14% rise in spend if services remain configured as they are currently.

Increasing cost of new technology

Technology is moving rapidly in several areas of pathology, driven by competition between suppliers to develop products which enable faster and more accurate results with greater efficiency.

These developing technologies will require a workforce that is adaptable and flexible to meet the technical challenges as well as clinical expertise to utilise these emerging diagnostics.

Atlas of Variation

Across our region we can see that there is wide ranging variation in the pathology diagnostics being provided. The 2013 Atlas of Variation highlighted differences in the relative activity across HCV ICS notably in cancer markers, therapeutic drugs, allergy, lipid and cardiac markers. No new census has been carried out but local analysis would suggest that there remains some variation across our region.

Workforce challenges – Sustainability of Services

Nationally there are difficulties in the recruitment and retention of highly specialised and skilled staff, in particular Consultant Histopathologists, but also consultants and Biomedical Scientists across a range of other sub-specialties. Locally we have seen long term medical and clinical staffing shortfalls. This on-going situation can lead to delays in diagnostic results or excessive locum and agency costs.

Response to the Mandate

The boards of HUTH and YTHFT established the Pathology Collaboration Board consisting of the clinical directors and managerial leads from each organisation with the remit to explore and develop a case for a pathology network that that will ensure the highest quality, sustainable and affordable pathology services across the healthcare system. The collaboration will require a long term partnership between the two trusts to deliver pathology services across the HCV region north of the Humber, but will also remain flexible to the inclusion of future partners, notably North Lincolnshire and Goole NHS Foundation Trust (NLAG).

Scope of the Collaboration and Service Review

The collaboration board carried out a high level assessment of the type of service options suggested by NHSI. An independent review of the current services and assessment of reconfiguration options was commissioned and the evaluation of these options forms the basis of the economic case and target operating model.

The review provided an assessment of what the service configuration would look like if there was no change in how the laboratory services are provided. This assessment forms the baseline against which the financial, workforce and productivity benefits can be achieved.

The Collaboration Board considered the scope of the laboratory disciplines to be included in the development of the Hull York Pathology Service.

All laboratory areas were included in the scope of the review and were divided into 3 sub-groups: Cellular Pathology, Microbiology and Blood Science (inc. haematology, blood transfusion, biochemistry and immunology).

Clinical services including Medical Haematology and Infectious Diseases are excluded but medical staffing input has been taken into consideration. Phlebotomy, Mortuary and Bereavement services were also excluded as these are not core laboratory disciplines.

The review team was given access to all activity, finance, estates, supplies and workforce data relating to both pathology services as well as NHSI model hospital reports. Activity from primary and secondary care and any activity from out of area sources and private sector was included in the analysis.

The review took into consideration, where available, national, regional and local clinical drivers that would impact on the pathology services.

The review process was overseen by a steering group comprising of representatives from the clinical disciplines in pathology and finance and business planning colleagues from both trusts. The steering group agreed the critical evaluation criteria in which to assess the various service reconfiguration options. The criteria were based on NHSI guidelines and adapted to take into consideration Humber Coast and Vale goals and objectives.

The Steering group developed a target operating model for the network to meet the challenges and needs of our community and local health economy.

Key principles for the Target Operating Model (TOM):

- The services offered will be necessary and appropriate for the care of our patients, taking into account the specific services provided by each individual hospital and the needs of Primary Care, the Community and other users, such as Mental Health.
- Patients and users will receive equitable access to diagnostic services and clinical advice, regardless of where their samples are processed. Where services are consolidated onto fewer sites to realise the benefits of working at scale, this will only occur when clinical quality and patient safety are not compromised.
- The services offered will support the national and local clinical priorities and support the needs of the local population.
- The clinical provision, services and tests offered will be available equally regardless of time of day/week requested. The service will provide a consistent diagnostic service to meet the standards set out in the NHS Seven Day Service Clinical Standards.
- We will be involved in the whole care pathway ensuring that diagnostic testing is evidence based and the test repertoire offered is appropriate and adaptable to the introduction of new tests and removal of redundant tests.
- Where clinically appropriate and effective we will introduce and support the use of diagnostic tests closer to the patient, point of care or smart technology for example.
- We will build stronger links with academic and commercial sectors to ensure that we are in the best position to take up opportunities to be at the forefront of new and innovative diagnostic tests and technologies.
- Clinical teams will reflect on the need to work with more specialist partners to ensure best outcomes for patients. Links with regional and national centres including (but not limited to) clinical networks, specialist diagnostic referral centres in Leeds and Sheffield, Genomic centres, and PHE laboratories.
- We will be a training centre of excellence for all grades of clinical laboratory staff and support the training and development of clinical staff across the region. The goal will be to train, develop and retain staff in all areas and provide career development opportunities whilst exploring innovative ways of working.

RECOMMENDATION 1

The steering group recommend that the following service configuration should be adopted:

1.1 For cellular pathology maintain two laboratories whilst consolidating specialist work. The specialist work will be consolidated to the HRI site.
1.2 For Microbiology the preferred configuration is to maintain two routine laboratory services at HRI and YH, (reduced from 3). This includes moving the microbiology laboratory from SH to YH and the consolidation of specialist work, principally virology, to HUTH.

1.3 For Blood Sciences the preferred configuration is to maintain two routine laboratories at HRI and YH, (reduced from 4). This option includes the consolidation of specialist work to one of the sites dependent on analytical capacity which would reduce duplication. Specialist tests will only be proved at a single laboratory site. The immunology laboratory would be consolidated to HUTH. For SH and CHH the service would continue to provide the acute clinical biochemistry and haematology services needed by the respective hospitals, as newly defined Acute Service Laboratories (ASLs). These ASL's have a much reduced repertoire of work. SH will provide the essential biochemistry and haematology tests necessary to support the acute hospital services, CHH will provide very limited testing that supports the rapid turnaround times necessary at the Queens centre, Cardiothoracic and ICU units.

This configuration of laboratories provides the flexibility to deliver significant service improvements for the region and will support a sustainable efficient pathology service for many years.

Steady State Comparison of Nominal Run Rate
In terms of the laboratory's annual savings, the table below shows the annual nominal cost of providing the service in the first full year of steady-state service. As agreed this is five years from the commencement of the collaborative, in this case this is financial year 2025/26. The expected annual saving at the point of steady state is £2,961k per annum. This represents a saving of 5.4% compared to the As Is model.

Scenario	As is	TOM	Savings	
	£000	£000	£000	%
Blood Sciences	31,243	29,499	1,744	5.6
Microbiology	10,766	10,097	669	6.2
Cellular Pathology	10,022	9,805	218	2.2
Central Pathology	2,392	2,062	330	13.8
	54,424	**51,463**	**2,961**	**5.4**

Organisational Form

In February 2018, NHSI published a guide on commercial and operational structures for consolidated pathology networks. Within the report it outlined that a new consolidated pathology network must have its own identity and operating flexibility that is distinct from the Trust's current management structures.

In this context the organisational form could be either a contractual joint venture (a form of contracting between the parties that does not use a separate vehicle) or a corporate joint venture (a joint working arrangement that uses the formation of a separate corporate vehicle).

After consideration of the advantages and disadvantages of each type of option, it was agreed that a contractual joint venture is the most appropriate fit for the new network.

RECOMMENDATION 2A

The Steering group recommend *a* ***Contractual Joint venture*** *with one of the trusts hosting the service.*

This would involve a single host organisation contracting for all the relevant services comprising the pathology network on behalf of both trusts.

This form is suitable where all parties are NHS bodies and does not involve the creation of a new legal entity. It involves the full integration of all pathology services to create an organisation hosted by one of the trusts but serving all trusts.

Hosting

In recommending a host the steering group considered the following; that the host trust should not be disadvantaged as part of the hosting agreement, the choice of the host maximises the potential financial savings in the short, medium and long term and the choice of host does not impact on the ability of the network to deliver its full range of services now and in the future. The host would manage the prime contract in accordance with the joint venture agreement that the parties enter into, and sub-contract relevant services to the other party.

Furthermore, the guidance provided by the legal advisors and NHSIE supports the creation of an oversight committee with equal representation at executive level from each of the partner trusts. Regardless of the host of contractual joint venture, the documentation underpinning the joint venture will set out the rights and obligations of each of the parties and includes those principles covered in the finance and management cases.

The proposed network would operate under a quasi-autonomous regime with its own management board with reporting requirements to the host trust. These reporting requirements would be defined by an approved Scheme of Delegation that would be part of a contractual Joint Venture Agreement between the parties

RECOMMENDATION 2B

The steering group determined that there are no clear differentiating operational factors when considering the recommendation for a host organisation. The legal advice is clear that in terms of access to York Teaching Hospital Facilities management LLP (YTHFM)and the associated cost savings, it is simpler for York Teaching Hospital Foundation Trust to be the host. Whilst similar levels of savings can be achieved via a contractual agreement between HUTH and YTHFT it would be necessary to give a clear rationale to the trust executive boards why the simpler option would not be selected. There are no strategic elements that would suggest either trust is better to host than the other; the steering group asked why would we not choose the most straightforward route? In that regard the steering group recommend the board's request YTHFT to act as the host organisation for the new pathology network. In making its recommendation the steering group would highlight to the trust boards that the underlying ethos of the new network is to develop a brand, an identity for the new Hull York Pathology Service.

Management Proposal

The final section of the business case outlines the high level actions and governance arrangements required to create the HYPS. The management case describes the control frameworks to be used to implement the proposed changes and manage the transition at 'go live'. Central to this will be the formation of an oversight committee and service board. This structure allows for a responsive service that is well-defined and where the operational management team has full control of operations at all sites. Each trust retains clinical influence through the clinical leadership represented on the oversight committee, (See Management case). Equally, strategic control is retained by all trusts through the network oversight board where all trusts have representatives and voting rights. The service management team will operate in accordance with a well-defined scheme of delegation. The new pathology network will require a degree of operational flexibility to set and execute its own priorities and objectives to grow as a sustainable service and to meet clinical needs of the HCV partners. The pathology network will be required to operate with a degree of autonomy in accordance with the standing orders and scheme of delegation of the host trust. Key to the governance process will be the creation of an oversight committee. This oversight committee shall have equal representation of the partner trusts and it is proposed that the committee is chaired by a non-executive for the partner trust.

At present each pathology/laboratory service has a senior management team in place. These teams will need to merge to form the management team for the new Hull York Pathology Service. The new senior management team will provide the organisational structure for the transformation of the pathology laboratory services across HUTH and YTHFT and operational management. The management team would develop the long term plan for the service and provide assurances to the executive boards on the progress and effectiveness of the new network through a pathology oversight committee.

Management cost summary

Current Structure	£	WTE
Medical Staff	90,800	0.4
Management	731,678	11.0
Administration	21,892	1
Total Current	**844,370**	**12.4**

New Structure	£	WTE
Medical Staff	129,000	0.8
Management	693,708	9.0
Administration	103,516	3.0
Operating Expenses (savings)	-44,000	
Total New	**882,224**	**12.8**
Additional Cost	**37,854**	

RECOMMENDATION 3

It is the recommendation of the steering group that in order to deliver the substantial reconfiguration of services outlined in recommendation 1, a new pathology management board should be appointed. This management board is described in detail in the management case. Furthermore, it is recommended that these appointments should begin as soon as practicable with authority to lead the new network through the transition period to the go live date for the joint venture.

Programme Plan

In order to deliver the network and begin the programme of work to harmonise working practices, consolidate specialist testing and introduce new innovative ways of working an outline programme has been developed (see Programme of Activities). For the network to be created and operate effectively there are a number of key enabling projects.

Key Enablers

In order to deliver the vision a number of key enablers have been identified as priority functions that are required to be in place to ensure success. The review highlighted that the success of the preferred configuration in recommendation 1 is dependent upon addressing these:

- Common informatics solutions – The Laboratory Information Management System (LIMS). The project to deliver a single LIMS for HUTH and YTHFT is underway with an anticipated go live date before Mar 2022.In addition; the services are integrating a common order communications (ordercomms) system for GP test requests.

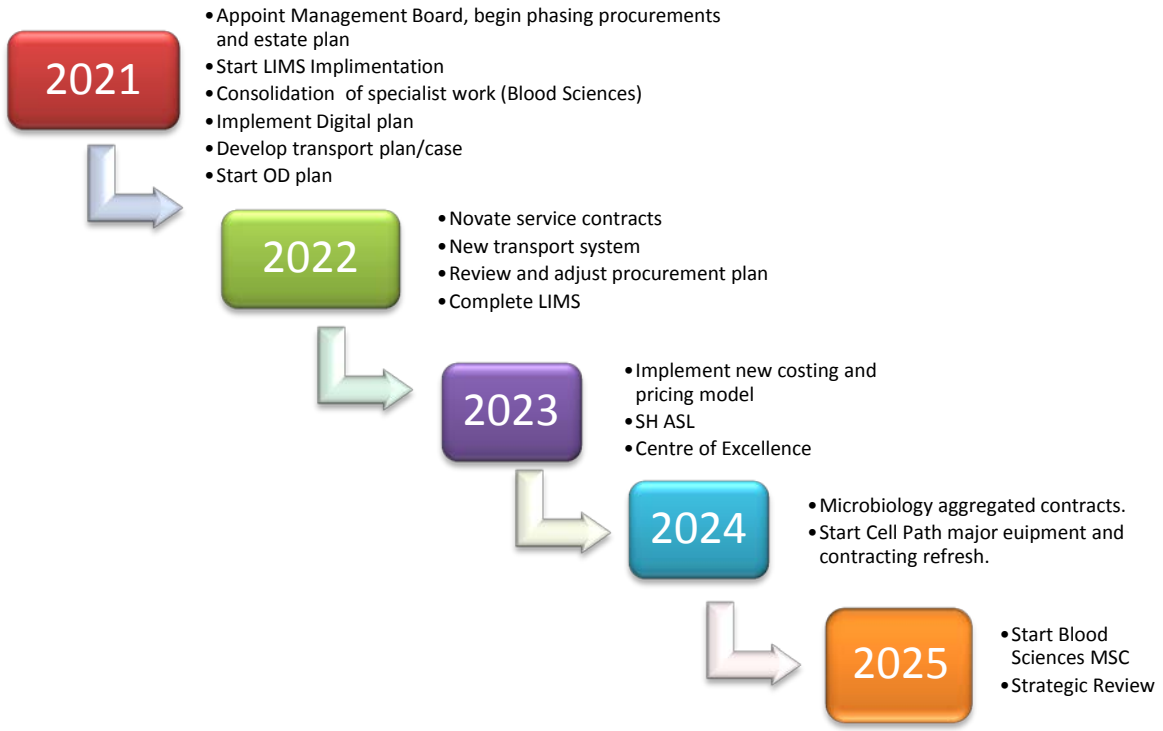
- Common equipment platforms - will allow standardisation to be effected across all laboratories.

- Common policies and procedures – In order to deliver a standardised accredited service.

- Implementing an effective and efficient transport system for the wide geographical area.

- Ensure appropriate functional, flexible and cost effective use of the laboratory estate that supports the delivery of the target operating model.

The HYPS board will be responsible for delivering these projects with highlight milestones (see road map Appendix G)



RECOMMENDATION 4

It is the recommendation of the steering group that the schedule of programme activities be accepted and partner boards support the request to the HCV healthcare partnership for the support of the diagnostic programme team to assist in the transition process. The programme will run through until 2023.

STRATEGIC CASE

Introduction

Pathology test results contribute to clinical decision-making in an estimated 70% of patient pathways. Pathology services support diagnoses and clinical decision making in all care settings including primary care, outpatient consultations, unplanned and planned inpatient care.

Pathology is a diverse discipline, with an estimated 7,000 different tests available globally across a range of key sub-disciplines:

- Clinical biochemistry; haematology; blood transfusion; and, immunology (collectively known as blood sciences).
- Bacteriology; virology; and, serology (collectively known as infection sciences or microbiology)
- Point of care testing (near to patient testing conducted by other care professionals).
- Histopathology; and, cytology (collectively known as cellular sciences or cellular pathology).
- Mortuary services including post mortems.
- Genetics and genomics
- Molecular pathology.

Approximately 50% of the current workload of Pathology laboratories is currently generated from GPs or other out of hospital services. Delivering a pathology service also involves logistics to transport samples from GP practices and other sample collection points to laboratories, and also moving samples between laboratories. Pathology services rely on pathology specific IT systems, or laboratory information management systems (LIMS).

Pathology tests also vary in the frequency of usage from very widely used tests such as full blood counts and liver function tests, through to very specialist and esoteric tests which are generally undertaken in specialist reference labs.

Some pathology results are required very urgently, for example to support diagnoses in A&E; whereas for others, 4 hours, 24 hours or even up to 6 weeks are acceptable. The frequency of usage and the required turnaround time are key factors which influence the optimal configuration of laboratories.

National Context

NHS Five Year Forward View and the NHS Long Term Plan

The NHS Five Year Forward View[1] (NHSE, 2014) set out an ambition to address growing demand for health care and reduce the variation in quality of care delivered by

[1] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

NHS services. At the same time, it recognized the need to improve efficiency and productivity in order to address an estimated funding gap of £30billion by 2020/21.

The NHS Five Year Forward View describes how, in order to sustain a comprehensive, high quality NHS, it will be necessary to develop new models of care with greater levels of integration between health and social care, requiring new partnerships with local communities, local authorities and service providers. The FYFV set out an aim of accelerating innovation in new ways of delivering care, as well as a greater emphasis on prevention and earlier diagnosis.
This was reiterated in *Next Steps on the NHS Five Year Forward View*[2] (NHSE, 2017) where specific reference was made to the need to ensure pathology services across England deliver the fastest and highest quality possible support to Trusts.

The NHS Long Term Plan echoes this view and states that by 2021, pathology networks will mean quicker test turnaround times, improved access to more complex tests and better career opportunities for healthcare scientists at less overall cost.

The context of health, care and support is changing, with people living longer, many with multiple and complex needs, and with higher expectations of what health, care and support can and should deliver. The combination of growing demand and continuing financial restraint mean that the NHS is under sustained pressure to realise efficiency savings to address a potential funding gap, estimated at £30 billion by 2021.

Lord Carter Review of Operational Productivity and Performance

Lord Carter's review of unwarranted variation in the operational performance and productivity in English Acute Trusts (2016)[3] identified efficiency opportunities of £5billion.

In Pathology, it was estimated that the total cost of NHS pathology services was between £2.5bn and £3.0bn per annum.

Lord Carter's Independent Review of NHS Pathology Services in England in 2008 gathered data and information that pointed strongly towards the consolidation of pathology services 'as a means of improving both service quality and cost effectiveness'. Further analysis confirmed that consolidated pathology organisations are the most efficient in the NHS. The Review recommended that all Trusts should achieve the acute pathology model hospital benchmarks by April 2017, or have agreed plans for consolidation with, or outsourcing to, other pathology providers by January 2017.

[2] https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

Development of Pathology Networks

NHS Improvement wrote to all acute Trusts in June 2016 requesting plans for the consolidation of pathology across STP footprints.

In September 2017 the National Pathology Implementation and Optimisation Delivery Group[4] signalled to all acute hospital trusts in England that they would need to change how they work and collaborate to drive out unwarranted variation in pathology services. The expectation was that pathology networks would be formed and that they would adopt a hub and spoke model of service delivery.

At that time, it was proposed that a Pathology Collaborative Network be established (North Midlands 2) comprising:

- Hull University Teaching Hospital (HUTH)
- Northern Lincolnshire and Goole NHS Foundation Trust (NLaG)
- United Lincolnshire NHS Trust
- York Teaching Hospitals NHS Foundation Trust. (YTH)

Following consultation, in September 2018, NHSI published an update to their 2017 proposal (*'Pathology – State of the Nation'*[5]) in which the North Midlands 2 network proposal was revised. The new North 7 network contained just Hull University Teaching Hospitals NHS Trust and York Teaching Hospitals NHS FT. United Lincolnshire and NLAG Trusts become part of the larger Midlands and East 2 network including Trusts at Northampton, Leicester and Chesterfield.

Local Context

Humber Coast and Vale Health and Care Integrated Care System

The Humber, Coast and Vale ICS footprint was established in 2016. It covers the areas of Hull, the East Riding of Yorkshire, North Lincolnshire, North East Lincolnshire, the Vale of York, Scarborough and Ryedale and North Yorkshire

[4] https://improvement.nhs.uk/documents/1658/Consolidation_Networks_CEO_Letter_RE11.pdf
[5] https://improvement.nhs.uk/documents/3240/Pathology_state_of_the_nation_sep2018_ig.pdf

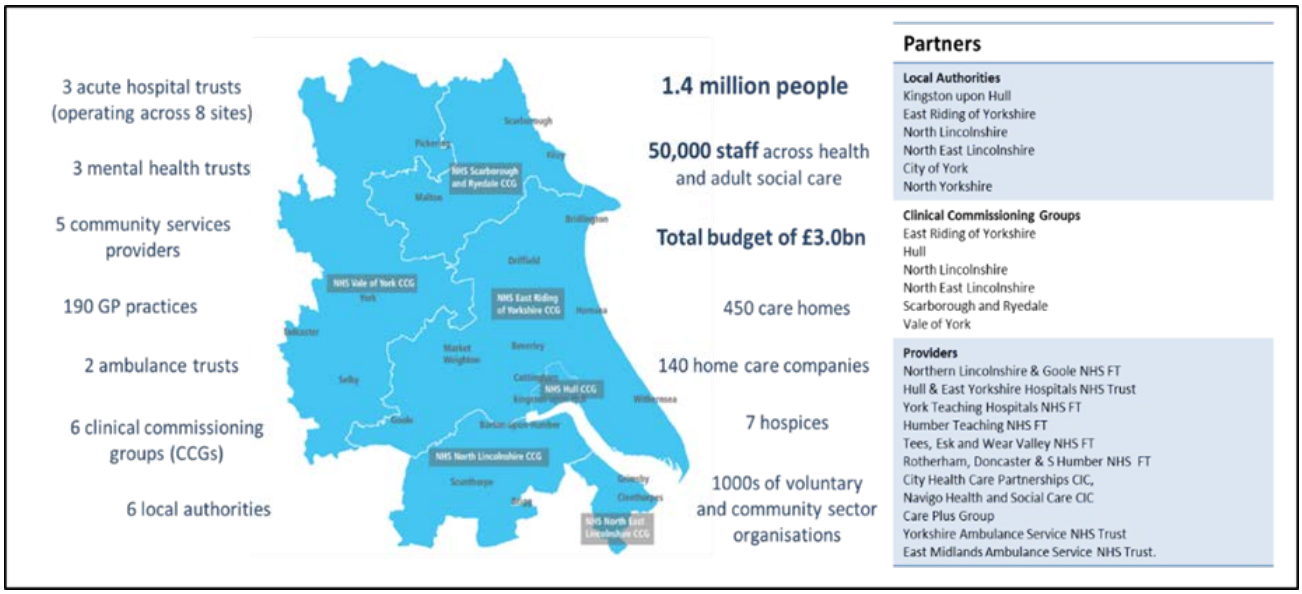


Figure 1: STP Patch

The HCV partnership's vision for its population is to: 'Start well, live well, age well'. The partnership's core clinical priorities are:

- ***Better 'Out of Hospital' Care, meaning people only go in to hospital when absolutely necessary***: there is therefore a need to ensure diagnostic capacity is sufficient to prevent unnecessary admissions to hospital and to support the management of patients in primary care and the community.
- ***Better Hospital Care, creating more efficient hospital based services and making the best use of resources and workforce across the system:*** Access to timely diagnostics will reduce patients' length of stay and time spent in the Emergency Department, improving the efficiency of hospital services.
- ***Better cancer care:*** needs to be supported by increased capacity and quality of diagnostic services, providing earlier diagnosis to reduce cancer wait times and improve outcomes.
- ***Balancing the Books:*** providing timely, efficient and effective diagnostics and reducing costs will assist in achieving an improved financial position across the HCV footprint.

A key element of the work of the HCV partnership is the strengthening of local partnerships, bringing together health and social care providers and commissioners in each of the six localities within the HCV area. Each local partnership has developed a place-based plan setting out their priorities for the coming years in relation to integration and improving the health and wellbeing of people in their local area.

The development of the place based plans will have a direct impact on the provision of Pathology services across the HCV region.

HCV commissioners and providers are working together to review acute hospital service provision, including urgent and emergency care services. One review is being

undertaken for the York/Scarborough area and a second review – the Humber Acute Services Review – covers the HUTH NHS Trust and NLAG Foundation Trust.

The reviews will consider how to provide the best possible hospital services for the people in the respective areas within the resources (money, workforce and buildings) available to partner organisations.

The reviews will consider both current and projected future needs for hospital services, taking into account local plans to improve and extend the types of care and treatment that are available outside of hospital settings. The purpose of these reviews is to develop plans for delivering acute hospital services that are safe, sustainable and meet the needs of our local populations, which may include delivering some aspects of care outside of hospital settings and/or in peoples' own homes.

The development of the HCV Pathology Collaborative will support the delivery of the ICS vision by:

- Ensuring that the region has an innovative and sustainable pathology service capable of adapting to the changing needs of clinicians and patients.
- Supporting clinicians and clinical teams to deliver integrated and patient-centred care.
- Attracting, developing and retaining the skills needed to deliver a modern pathology service, and utilising these skills efficiently and effectively across the region.
- Investing in the skills and technology needed to deliver modern diagnostics, through pooling resources and undertaking testing at scale where appropriate.
- Providing an efficient, effective and high quality pathology service which will contribute to delivery of financial efficiencies across the H&CV partnership both through direct pathology savings and through facilitating savings elsewhere in the health and social care system through supporting integrated pathways across the acute, community and primary care settings.

HCV Pathology Service Providers

Pathology services within the HCV footprint are provided by:

- Hull University Teaching Hospitals NHS Trust
- York Teaching Hospitals NHS Foundation Trust
- Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (via Path Links[6], a single managed clinical pathology network operating across Lincolnshire).
- Harrogate and District NHS Foundation Trust.

[6] Path Links was formed in 2001 by the amalgamation of NHS pathology services in Boston, Grantham, Grimsby, Lincoln, and Scunthorpe. It is the main service provider for the Lincolnshire STP. NLAG has continued to host Path Links since July 2018 for the provision of pathology services for the North Lincolnshire region and wider Lincolnshire STP.

In May 2017 a Memorandum of Understanding (MoU) was agreed between the three pathology providers to explore and develop the consolidation of pathology services across the HCV and Lincolnshire STPs.

However, with NHSI's reconsideration of their Pathology Network plan in September 2018, and the separation of the Hull and York pathology services from the Path Links organisations, the MoU became null and void.

In July 2018 HUTH and YTH Trusts stated their intention to collaborate on the creation of a single pathology entity that offers laboratory services for the HCV region north of the Humber (the Hull York Pathology Collaboration). This collaborative approach to forming a network was accepted by NHSI (and referred to as North 7 Hull York Pathology Services).

The Pathology Collaboration programme began in September 2018 to develop the future plan for delivering pathology services for Hull and York acute hospital trusts and associated primary and social care organisations in the region.

Harrogate and District Foundation Trust pathology service is delivered by Integrated Pathology Solutions LLP (IPS), a joint venture between the Pathology departments of Harrogate and District NHS Foundation Trust, Airedale NHS Foundation Trust and Bradford Teaching Hospitals NHS Foundation Trust.

Hull University Teaching Hospital (HUTH) clinical portfolio is comprehensive, covering the major medical and surgical specialties, routine and specialist diagnostic services and other clinical support services. These services are provided primarily to a catchment population of approximately 600,000 in the Hull and East Riding of Yorkshire area and operates from two main sites - Hull Royal Infirmary and Castle Hill Hospital – whilst delivering a number of outpatient services from locations across the local health economy area

HUTH provides specialist and tertiary services to a catchment population of between 1.05 million and 1.25 million extending from Scarborough in North Yorkshire to Grimsby and Scunthorpe in North East and North Lincolnshire respectively. The only major services not provided locally are transplant surgery, major burns and some specialist paediatric services.

York Teaching Hospitals NHS Foundation Trust (YTHFT) provides a comprehensive range of acute hospital services. In July 2012 YTHFT acquired Scarborough and North East Yorkshire Healthcare NHS Trust, bringing Scarborough and Bridlington Hospitals into the organisation.

It serves approximately 800,000 people living in and around York, North Yorkshire, North East Yorkshire and Ryedale – a mixed urban and rural population across 3,400 square miles.

HUTH and YTHFT host extensive pathology services, providing over 26[7] million tests per annum.

The services employ over 530 wte staff distributed across 4 hospital sites:

- Hull Royal Infirmary (HRI)
- Castle Hill Hospital (CHH)
- York Hospital (YH)
- Scarborough Hospital (SH)

The combined annual budget for these services is circa £46.8m. (2020/21)

The HUTH pathology service has an extensive clinical portfolio. A number of specialised pathology services are provided including neuropathology, virology and immunology.

The York pathology service provides a wide range of laboratory clinical services for YTHFT and has existing detailed proposals and ongoing developments for the relocation of microbiology services from Scarborough Hospital.

HUTH

YTHFT

[7] Model Hospital Annual Data set

Figure 2: Scope of services
(Laboratory disciplines unless otherwise stated)

The Case for Change

NHSI Pathology Network Review

As identified in sections above, as a result of the NHSI Pathology Network Review, Hull and York pathology providers have been identified as the North 7 Hull York Pathology Services (HYPS). With a requirement for all networks to be in place by 2021, there is a need for the Hull and York pathology services to work together to develop a collaborative model which meets the needs of the local population and delivers improvements in clinical quality and patient experience. The HCV Partnership has agreed to the creation of a programme of work to bring about the required system change.

Growing demand and increased test complexity

As with other healthcare services, demand for pathology is growing both in the number of test requests and in the complexity of tests requested. This is driven by:

- An ageing population with increased prevalence of long term conditions;
- Clinicians undertaking more diagnoses prior to making decisions regarding treatment;
- The availability of new tests, for example: companion diagnostics, which enable better targeting of drugs, or personalized medicine.

Over the next 5 years, pathology demand in Hull and York is projected to grow across all specialties and sources (hospital, GP and community). Sample growth is projected to grow 6% from current levels by 2022/23, driven mostly by demographic growth. Test growth is predicted to grow 15% from current levels by 2022/23, driven by greater testing per sample (higher sample to test ratio in aging population).

The implied financial impact of this increased demand is a rise in spending to £54.4m if services remain configured as they are currently. This is predominantly driven by increased staffing costs. The biggest staffing increases are projected to be among analytical staff (BMSs), driven by test-level growth

NHSI are encouraging the formation of laboratory networks to address these challenges through consolidation of specialist and routine testing on fewer, more sustainable sites (and to deliver increased capacity for e.g. training, research and innovation in service delivery including through point-of-care testing). However, there are significant local context factors for Hull, York and Scarborough which it is believed will limit the ability to establish the archetype “hub-and-spoke” model being explored elsewhere. Most notably the geography of the region; the relative isolation of the clinical sites limits the mobility of staff and impacts on redeployment of staff to new sites of working.

Increasing cost of new technology

Technology is moving rapidly in several areas of pathology, driven by competition between suppliers to develop products which enable faster and more accurate results with greater efficiency. Some tests will be diverted to central diagnostic facilities i.e. Genomic Medical Centre’s but there will be career development opportunities for staff working in laboratories within the region. Some of the key trends are:

- Developments in genetic or molecular technology - These enable the rapid identification of viruses and other pathogens, as well as testing human genetic material to support a range of clinical decisions including: identify risk of inherited disease; identify the likely efficacy of certain drugs or treatments; and, improve diagnosis and monitoring of oncology patients.

- Improved automation- Automation within blood sciences has been common, but the technology is improving and the automation of microbiology labs is now starting to offer greater benefits. Overall the cost effective availability of analytical systems is driving the skills mix in large laboratories, more band 4 and 5 staff needed, releasing band 6 upwards for specialist/advanced practice.

- Digital technologies - Digital histology is at a much earlier stage of development than digital radiology, but improvements are likely to lead to greater adoption, allowing movement of images to support MDTs, second options and the ability to send images across the country and potentially internationally for interpretation and reporting to assist with workload pressures resulting from vacant positions. This technology is currently being

installed at both cellular pathology sites and in January 2021 will join the National Pathology Imaging Collaborative (NPIC) being led by Leeds Teaching Hospitals.

- Improved point of care testing (POCT) - Point of care testing is more expensive than testing in a conventional laboratory, but the range of tests, accuracy and cost are improving, and overall pathway costs and outcomes can be improved, in some cases through more rapid availability of results. Working with clinicians on pathways will give a greater understanding on the appropriate use of POCT.

These developing technologies will require a workforce that is adaptable and flexible to meet the technical challenges as well as clinical expertise to utilize these emerging diagnostics.

Atlas of Variation

Across our region we can see that there is wide ranging variation in the pathology diagnostics being provided. The 2013 [8]Atlas of Variation highlighted differences in the relative activity across HCV Healthcare Partnership notably in cancer markers, therapeutic drugs, allergy lipid and cardiac markers. No new census has been carried out but local analysis would suggest that there remains some variation across our region.

Workforce challenges – Sustainability of Services

Nationally there are difficulties in the recruitment and retention of highly specialised and skilled staff, in particular Consultant cellular pathologists[9], but also consultants and biomedical scientists across a range of other sub-specialties. Cellular pathology Consultants have an older than average age profile and vacant posts have been unfilled for several years. Combined vacancy rates are in the order of 40%. This on-going situation can lead to delays in diagnostic results or excessive locum and agency costs

Response to the Challenges

In order to address these challenges, the Boards of HUTH and YTHFT asked their respective Pathology directorates to consider how they could work together to provide a single pathology service for the HCV region north of the Humber. A Pathology Collaboration Board was established consisting of the clinical directors and managerial leads from each organization.

8 https://ukgtn.nhs.uk/fileadmin/uploads/ukgtn/Documents/Resources/Library/Reports_Guidelines/Right_Care_Diagnostics_Atlas_2013.pdf

9 https://www.rcpath.org/uploads/assets/952a934d-2ec3-48c9-a8e6e00fcdca700f/Meeting-Pathology-Demand-Histopathology-Workforce-Census-2018.pdf

Board Remit

The aim of the collaboration programme is to develop a network that will ensure that the highest quality, sustainable and affordable pathology services are delivered across the healthcare system. The collaborative will position the Hull York Pathology Services to support the redesign of patient pathways through progressive and transformational change, ensuring that the services are able to respond to the challenges of the evolving health care environment. The collaboration will establish the case for a long lasting partnership between the partner trusts to deliver Pathology services across the HCV region north of the Humber, but will also remain flexible to the inclusion of future partners, notably NLAG.

The guiding goals to be achieved and demonstrated in this business case are detailed below:

Guiding Goals	
Goal 1.	Ensuring that the HCV region has an innovative and sustainable pathology service capable of adapting to the changing needs of clinicians and patients.
Goal 2.	Supporting clinicians and clinical teams to deliver integrated and patient centered care.
Goal 3.	Develop and retain the skills needed to deliver a modern pathology service, and utilizing these skills efficiently and effectively across the region.
Goal 4.	Use technological innovation to deliver modern diagnostics including testing at scale, where appropriate.
Goal 5.	Be an efficient, effective and high quality pathology service which will contribute to the financial efficiencies, both through direct pathology savings, and through facilitating savings elsewhere in the health and social care system through supporting integrated pathways across acute, community and home settings.
Goal 6.	Stronger links with academic and commercial sectors to increase opportunities to be at the forefront of new and innovative diagnostic tests
Goal 7:	Supports future options for expanding the network with near neighbours and, if applicable, wider geographical partners i.e. WYATT, Sheffield and North Yorkshire networks.

Table 1: The guiding goals of the Hull York Pathology Service

Scope of the Collaboration

The collaboration board carried out a high level assessment of the type of service options suggested by NHSI. An independent review of the current services and assessment of reconfiguration options was commissioned and the evaluation of these options forms the basis of the economic case below.

The review team provided an assessment of what the current service configuration would look like if there was no change in how the laboratory services are provided. This assessment forms the baseline against which the financial, workforce and productivity benefits can be achieved.

Key Enablers

In order to deliver the vision a number of key enablers have been identified as priority functions that are required to be in place to ensure success. The independent review confirmed that the success of the preferred option is dependent upon addressing these areas:

- Common informatics solutions - It is essential that informatics solutions providing seamless electronic access to results across the HCV footprint are in place to underpin the vision for the future. The transfer of results between laboratories and hospital sites, GP surgeries, external laboratories, locality hubs and patient records is key to the quality and deliverability of the Pathology service. In 2020 the Hull York Pathology Service started implementing a single integrated Laboratory Information Management System (LIMS). In addition, the services are integrating a common order communications (ordercomms) system for GP test requests which will align with the system already in place in York and enable wider regional sharing of results. These developments will underpin the wide ranging service transformations outlined in the business case.

- Common equipment platforms - To ensure continued service quality common equipment platforms will allow standardisation of reference ranges to be effected across all laboratories.

- Common policies and procedures – In order to deliver a standardised service across all areas common policies and procedures will be developed to support standardisation of tests, improving quality of service to patients and support the accreditation of the laboratories.

- Effective and efficient transport systems – Given the potential increase in specimens taken out of hospital, it is essential that effective and efficient transport systems are in place. There will need to be systems in place to support additional transport between sites to enable planned consolidation of services

- Appropriate functional, flexible and cost effective estate – The reconfiguration of services will take into account the requirements of each acute hospital site, including the requirement for a full emergency and inpatient service.

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ECONOMIC CASE

Introduction

The following section will provide a review of the work that has been undertaken to determine the preferred option and will outline the proposed way forward following a review of all the potential laboratory configuration options that have been considered.

Review of the Long List

The collaborative board developed and considered a number of options in relation to the overall configuration model to be adopted across the 2 Trusts. These options were assessed in terms of their potential to deliver the guiding goals listed above in table 1 on page 25 .

The long list of options is shown in the following table (table 2) along with the advantages and disadvantages of each model. An assessment has been made whether the models will achieve the 'Guiding Goals' and this has been used as a mechanism to discount those options that will not be taken forward.

This exercise has determined that there is only one potential configuration model that will deliver the required outputs which is the Development of a managed or distributed network service that functions as a single Pathology Network.

Option Name	Description	Advantages	Disadvantages	Scheme objectives and critical success factors
1 Business as Usual (BAU)	Keep the existing service configuration and continue to operate as individual Pathology services	Staff familiarity	Services would be unable to deliver the scale of expected savings. Variation would continue. Workforce shortages in key staff groups could not be resolved on a Network basis. Would not meet the NHSI mandate to develop Pathology Networks	Does not meet the guiding goals. To continue in our current form will lead to growing levels of inefficiencies and service variance across the region. To remain would limit the ability of either service to introduce new

Option Name	Description	Advantages	Disadvantages	Scheme objectives and critical success factors
				ways of working or technology **Discounted Fails all guiding goals**
2 Centralise all laboratory services into a new build facility	All laboratory services re located into a single purpose build facility in a centralised location and essential service laboratories[10] (ESL's) in each hospital	Would allow standardisation across all disciplines, consolidate equipment assets	This option would require substantial capital funding that is not currently available. Current infrastructure is largely fit for purpose and housed within clinical services at each Trust. Geographically, the area covered is too vast for a single site model, maintaining adequate acute hospital support limits ROI. Would restrict future service reconfigurations.	Does not meet the guiding goals. From the outset it was clear that the proposed network would not have access to the level of capital necessary to build on new purpose built facility. **Discounted: Fails on goal 2,5,6.7.**
3 Develop a hub and spoke model	Centralise all laboratory services into an existing single site hub and maintain ESL's at each spoke (acute hospital)	Would allow standardisation across all disciplines, consolidate equipment assets	Unlikely to deliver the scale of savings required, Each Trust currently processes similar number of samples therefore no obvious Hub. Would require substantial alteration to the estate to accommodate the volume of work at the hub, unpredictable level of ROI. Essential service laboratories (aka Hot labs) will not meet the local needs of the acute hospitals.	Does not meet the guiding goals. Neither trust has the estate suitable for the cost effective modification needed to be the host for a single hub. The geographical constraints of the network would require substantial resources to be placed at each acute trust. **Discounted: Fails on goals 2,4,5,6,7**
4 Develop a managed or distributed network service that functions as a single Pathology Network	One single Pathology Network managed across multiple sites with consolidation where appropriate and laboratory provision where clinically required at acute sites.	Suits the geographic scale of the patch to be covered. Consolidation of high cost tests delivers greatest savings. Provides the flexibility of services to meet changing clinical demand. It supports consolidation of	Uncertainty during implementation may affect retention of staff.	Provides the best opportunity to meet the guiding goals. A distributed model of services will ensure the best and most effective

[10] https://improvement.nhs.uk/documents/2366/Template_structure_for_ESL_blood_sciences_RE03.pdf

Option Name	Description	Advantages	Disadvantages	Scheme objectives and critical success factors
		any single laboratory discipline to one site and therefore economy of scale potential. Workforce challenges mitigated. Requires minimum capital investment and supports best use of current laboratory space. Services maintained at acute trust sites		**Preferred Way Forward that can be developed to meet the guiding goals.**

Table 2: Long list of options

Preferred Way Forward

The Pathology Collaboration Board in discussion with NHSI confirmed that the future configuration of Pathology service would be as a single Network with managed or distributed services across the patch.

This option can be delivered in a number of ways with various potential configuration options available within each laboratory discipline.

In order to support the development and assessment of the potential options, an independent review was commissioned by the two Trusts.

Independent Review

The board commissioned an independent consultancy to review and analyse the current services provided by Hull and York and to facilitate the exploration of various reconfiguration options.

The objective of the review was to identify the most appropriate, evidence-based, laboratory services configuration across the region. As part of the work carried out, the review outlined the challenges presented by doing nothing or very limited changes.

The review team was given access to all activity, finance, estates, supplies and workforce data relating to both pathology services as well as NHSI model hospital reports. Activity from primary and secondary care and any activity from out of area sources and private sector were included in the analytics.

The review team took into consideration where available national, regional and local clinical drivers that would impact on the pathology services.

The review process was overseen by a steering group comprising of representatives from the clinical disciplines in pathology and finance and business planning colleagues from both trusts. The steering group agreed the critical evaluation criteria in which to evaluate the various service reconfiguration options. Key stakeholders from the service user group were also asked for input into these criteria. The criteria were based on NHSI guidelines and adapted to take into consideration Humber Coast and Vale goals and objectives. These critical criteria were agreed as key indicators to how each options meets the guiding goals. These criteria are listed in the strategic case and below

Guiding Goals	
Goal 1.	Ensuring that the HC&V region has an innovative and sustainable pathology service capable of adapting to the changing needs of clinicians and patients.
Goal 2.	Supporting clinicians and clinical teams to deliver integrated and patient centered care.
Goal 3.	Develop and retain the skills needed to deliver a modern pathology service, and utilizing these skills efficiently and effectively across the region.
Goal 4.	Use technological innovation to deliver modern diagnostics including testing at scale, where appropriate
Goal 5.	Be an efficient, effective and high quality pathology service which will contribute to the financial efficiencies, both through direct pathology savings, and through facilitating savings elsewhere in the health and social care system through supporting integrated pathways across acute, community and home settings.
Goal 6.	Stronger links with academic and commercial sectors to increase opportunities to be at the forefront of new and innovative diagnostic tests
Goal 7:	Supports future options for expanding the network with near neighbours and, if applicable, wider geographical partners ie WYATT, Sheffield and North Yorkshire networks

Critical Success factors for the Options	
Clinical quality	Does the option deliver high-quality services consistent with agreed standards?
Patient safety	Does the option provide appropriately accessible, responsive & safe services for clinicians and patients
Facilities, IT & equipment systems	Does the option maximise productive use of capacity (existing & new)
Achievability	Is the option likes to deliver sustainable change in the next 3-5 years?
Workforce	Is the option staffable, providing attractive roles and training, addressing existing staffing pressures?
Affordability & value for money	Does the option deliver financially viable providers in both the short and long term?
Strategic fit	Will the option support other local and regional strategic changes and goals?
Control & governance	Will the option maintain Trust oversight while enabling innovation?
Education & Research	Is the option likely to support delivery of education and research?

The process included four speciality reference groups (SRG) with members across the range of staff in each discipline. The SRGs each met on three occasions to review and assess the options based upon the critical evaluation criteria. At each stage of the review process the SRG provided a qualitative assessment, highlighting the positive and negative impacts of each option. The finance group met separately to aggregate finance and activity data. A separate central services reference group met to discuss the enabling activity relating to each service reconfiguration option. The Steering group considered the reports from the review team and SRG's challenging the assumptions and holding the groups to the scope of the review. The steering group agreed to adopt the principle providing laboratory facilities at each hospital site which may involve setting up Acute Service Laboratories (ASL's). These ASL's would be specifically designed to meet the needs of the hospital that they are located in. Equipment, staff and test repertoire to match the hospitals acute clinical needs. See detail in the Target operating Model section.

The review process began in February 2019 and the final report was submitted to the trust pathology steering group on 26 April 2019. The final report provides an evidence-based assessment of potential future laboratory configurations which includes the projected demand, implied workforce requirements in the next five years, the assessment of future options, shortlist of laboratory reconfiguration options and how these options score against the evaluation criteria. The report also includes the financial implications of each of these options.

Scope

The collaboration board considered the scope of the laboratory disciplines to be included in the development of the Hull York pathology service.

All laboratory areas have been included in the scope of the review with the following exceptions:

- Clinical services including Medical Haematology, and Infectious Diseases have been excluded but medical staffing input has been included in the model. These are not primarily laboratory disciplines.
- Mortuary and bereavement services. These services are more closely aligned to clinical areas and each trust is contracted separately to the local authority and coronial service.

- Phlebotomy services are provided by multi clinical areas and not just pathology. Each trust has their own Phlebotomy service that is independent of the pathology service.

Identifying the Options

Each Laboratory discipline has been considered in detail as part of the review and the following tables outline the short list of options within each discipline. These options were developed by the SRG's and assessed by the steering group as part of the review process

The tables below show the list of options, the advantages and disadvantages of each option and which option is recommended by the steering group.

Pathology/Laboratory Medicine divisions constitute multiple departments. These departments function in the main independently of each other but are often co-located. The steering group assessed the combination of the options from the SRG's to determine if the combined option meets the guiding goals and if the adoption of one option impacts on other departmental options. Essentially the steering group assessed if the adoption of any laboratory option impacted or prevented the adoption of another laboratory option.

Cellular Pathology: Option Appraisal

Cellular Pathology is currently delivered at Hull Royal Infirmary and York Hospital. The service supports the delivery of clinical services in the acute trusts and some primary care activity. The nature of the service does not lend itself to large scale automation opportunities. National shortages of medical staffing in the field are replicated locally with significant shortfalls in Hull and York. The services are currently investing the latest digital technology that will support flexible working and shared reporting. The independent review highlighted HRI as the most appropriate site for the single laboratory option 2.

Option Name	Description	Advantages	Disadvantages	Scheme objectives and critical success factors
0. Do nothing plus	Retain all services as they currently are. Laboratory and reporting facilities at HRI and YTH. Shared procurements and consolidation/repatriation of some specialist testing	Does not require large financial investment to maintain current levels of service. Staff familiar and settled at current locations. Ability to share and move reporting between consultants based at HUTH and YTH using digital pathology or transfer of slides	Limits ability to introduce new technologies and tests across the network. Duplication of technology in particular digital systems, potential source of diagnostic variation and duplicated costs. Performance variation, different demands and capacity fluctuations between sites. Significant medical staffing shortages nationally impact on the ability of both services to recruit. Unfilled posts vary between trusts and mitigating actions leads has meant there is variation in performance between the two services. The risk of no investment in new technology due to duplication of resources would make the service unsustainable in the mid-long term.	**The SRG and Steering group determined that whilst Do Nothing option failed to meet the goals and critical success criteria a variant of the option in which some of the more specialist testing could be consolidated to a single site, (HRI). The tests that would consolidated are those which are currently referred out or are secondary tests supplementary in the main to normal diagnostic tests. This option has the benefit of offering cost savings at a later date when equipment needs replacing.** **Carried Forward with amendments to the definition of specialist test.**
1. Maintain 2 existing sites but consolidate specialist testing to a single site	Maintain the 2 existing sites but consolidate all specialist testing to one site. The preferred site for consolidating specialist work was HRI	Potential to reduce duplicate costs of some equipment.	Substantial clinical risk associated with moving specialist testing to one site. Significant performance risk (TAT) that cannot be adequately mitigated. High levels of risk associated with delayed diagnostic reporting.	This option was assessed on the basis of all but the most routine of work would be referred to HRI as the cellular pathology laboratory that has the best space available. The SRG concluded that separating the routine and specialist work posed a significant risk of poor performance for YTHFT. This variance between partner trusts could not be adequately mitigated against. In addition, there was no significant financial benefit for adopting this model above the Do Nothing Plus.

Option Name	Description	Advantages	Disadvantages	Scheme objectives and critical success factors
				The independent review concluded that this options represents a significant clinical risk and should be discounted. The steering group agreed that the definition of specialist testing from the review team was too broad and as such encompassed tests that are routine for any normal cellular pathology services. The steering asked the reference group to revisit the definition. The conclusion was that there are some tests, low volume, high costs that could be considered as specialist and only provided at a single laboratory site. According the recommendation was to consolidate this work. This change is reflected in option 0 above. Discounted
2. Single cellular pathology laboratory with digital reporting at both sites	A single cellular pathology laboratory processing samples from all hospitals at HRI A small facility will be maintained on the alternative site to handle urgent samples if necessary (see ASL defn) at YH. Reporting by medical consultants including digital reporting will be maintained at both sites.	Consolidation of testing increases potential quality benefit and minimises provision of sub-scale testing. More feasible to invest in technology at scale where testing volumes are larger (both for specialist and routine) Avoids duplication of equipment, Standardisations of processes and potential to roll out changes across the community. Volume and scale of main laboratory will offer wider	Risk of worse turnaround for full consolidation model due to dependency on transport. Transport of surgical material between sites in single routine lab model poses logistical challenges. Loss of connection to the main laboratory site by those working on the alternate site. Potential significant HR implications (loss of staff) in the short term to scaling down one of the laboratories. Significant negative impact, financial (redundancy costs) and operational effectiveness in the short term	This option is dependent upon successful rollout of digital reporting and harmonisation of working practices. These are elements that could not be delivered in the short term due to the immaturity of the technology involved and the lengthy training pathways. There is a high likelihood of significant loss of staff from York with this option. This clinical area is identified as having national shortages of key staff (consultants in particular) Achieving the TOM is impracticable in the short term/medium term. The financial benefit of this option is low and is negated

Option Name	Description	Advantages	Disadvantages	Scheme objectives and critical success factors
		opportunities for staff development. Dual sites for reporting will enable the consultants to maintain their connections with clinical teams in each trust (addressing different clinical needs that exist in the trusts)		by the high cost of mitigating the HR risks **Discounted**

Table 3: Cellular Pathology Options

Cellular Pathology: Recommended Option

The steering group recommend that the configuration for cellular pathology is to maintain two laboratories for routine diagnostic work whilst consolidating lower volume and higher cost specialist work. The specialist work will be consolidated to the HRI site and will be explored in detail during the transition period.

In order to maximise efficiencies there are some critical enabling activities that need to be completed, a) full implementation and roll out of digital reporting that would enable medical consultants to report regardless of physical location, which will also support accessing regional support ie LTHT and STHFT b) utilisation and introduction of advanced practitioners (biomedical scientists or clinical scientist) across the network, which will mitigate the recruitment risk for medical staff and potentially provide a sustainable workforce for the future c) the harmonisation of clinical practice.

These critical activities need to be completed in order to reach the target operating model. This will realise much of the desired reduction in variation and increase resilience and specialisation without putting the trusts at a severe short term risk from potential loss of staff. Digital

pathology, common IT systems and standardization of procedures will enable consolidation and sharing of scarce clinical and advanced practitioner capacity without jeopardising recruitment or retention.
It is therefore the recommendation of the steering group that the target operating model can be achieved by maintaining cellular pathology laboratory facilities on both sites. There are no substantial financial benefits identified for delivering a single laboratory option at this time. A single laboratory will result in a level of clinical instability that will inhibit the transformative changes needed to meet the principle objective of an innovative and sustainable service. The proposed option represents a necessary step for the progressive development of cellular pathology that will enable the service to meet the future challenges posed by growing complexity in demand and the expectation to reduce diagnostic turnaround times. Development of digital reporting and advanced scientific roles together with a single management structure will support improved service performance and resilience and reduce reliance on medical agency staff and referring samples away.

The recommendation of this option does not impact on the microbiology or blood sciences options.

Microbiology: Option Appraisal

Microbiology is currently provided from Hull Royal Infirmary, York Hospital and Scarborough Hospital. Virology is delivered from the Castle Hill Hospital site but will move to new purpose built accommodation in early 2021 These services provide support to acute clinical services and the wider primary care providers. The microbiology laboratories are closely tied to infection and pharmacy services. The review process recognised that there are significant clinical variances in how medical microbiology services are provided in either trusts and as such the degree of laboratory harmonisation is affected by the clinical services in the separate trusts. In looking at the provision at Scarborough Hospital it was recognised that there was an existing plan to move the microbiology laboratory to York Hospital. The steering group adopted this plan and agreed that some microbiology testing fall within the scope of an Acute Service Laboratory (ASL).

Option Name	Description	Advantages	Disadvantages	Scheme objectives and critical success factors
0. Do nothing plus	All services remaining as they are with agreement to undertake joint	Access to service maintained at all sites.	Multiple sites leading to duplication of effort and variation of testing.	Both of these options were discounted as the decision has already been

Option Name	Description	Advantages	Disadvantages	Scheme objectives and critical success factors
	procurement and repatriate work currently sent out of area.		Higher staffing levels needed to maintain services based on projected growth in demand	taken to scale down the Scarborough site and relocate to York. The level of activity for SH and the surrounding primary care teams is unsustainable, requiring extensive investment in the laboratory facility and additional staff. This activity can be absorbed by YH with a modest adjustment to the infrastructure. For SH the provision of acute microbiological testing can be delivered using innovative technologies and in the development of multidisciplinary workforce in an Acute Service Laboratory (see TOM ASL) **Discounted**
1. Maintain 3 existing microbiology Labs but consolidate specialist testing to a single site	Maintain the existing 3 laboratories at Hull / York / Scarborough. Relocate virology to HRI(close down CHH Virology lab) and consolidate the specialist testing to one site	Access to services maintained at 3 sites.	Multiple sites leading to duplication of effort and variation of testing. Duplication of equipment. Higher staffing levels needed to maintain services based on projected growth in demand.	
2. Maintain sites at Hull and York and consolidate specialist testing to a single site	Maintain labs at Hull and York with an ASL at Scarborough to support the acute site using rapid diagnostic methods. Relocate virology to HRI (close virology lab) Specialist testing would be consolidated to match where the analytical and estate capacity is.	Specialist turn-around times are likely to be improved. Standardisation of methods across sites, remove duplications and analytical variation. Dual sites for routine work will enable the clinical teams to work effectively with clinical teams in each trust (addressing different clinical needs that exist in the trusts)	Risk of disconnect from local hospital services. Will be a challenge to maintain staffing competency at ASL. Relocation of Scarborough microbiology to York is inhibited by the lack of space.	**Preferred Option**
3. Single microbiology lab with consolidated specialist testing and rapid diagnostic capability within ASL at 2 other sites	A single cold and consolidated specialist testing lab at HRI with ASL at York and Scarborough.	Standardisation of methods. Specialist turn-around times are likely to be improved. ,remove duplications and analytical variation Greatest opportunity for procurement savings.	Risk of disconnect from local hospital services. Will be a challenge to retain staff at ASL's. Risk loss of staff due to less attractive nature of the job in ASL. Potential for significant negative financial impact (redundancy costs)	The option for a single laboratory severely limits the ability of the laboratories to adapt to local needs. It is an essential element of the microbiology laboratory that the medical microbiology team work in close proximity to the laboratory, in

Option Name	Description	Advantages	Disadvantages	Scheme objectives and critical success factors
			and operational effectiveness in the short term. Capital investment needed to accommodate predicted demand at a single site. Transportation of labile and high risk biohazard samples.	order to deliver a single laboratory and medical microbiology service. A single laboratory would involve moving to a single site or staying in their location away from the laboratory. In both scenarios there is a significant negative impact on service quality. In addition, the independent review has shown that maintaining two routine laboratories will provide greater opportunities for significant efficiencies and service improvements than the single laboratory option. The steering group therefore discounted this option. |Discounted

Table 4: Microbiology Options

Microbiology: Recommended Option

the preferred configuration is to maintain two routine laboratory services at HRI and YH. This follows on from existing proposals in which the microbiology laboratory at SH is moved to YH. This configuration includes the consolidation of specialist work, principally virology, to HUTH. The option will allow HUTH and YTHFT to deliver bespoke medical microbiology care for their hospitals and local communities while still permitting laboratory consolidation and harmonisation of analytical processes. Virology which will be provided in the new facility at HRI.

A single laboratory option has a number of shortfalls; the review proposed the single site to be at HRI. This option poses significant clinical issues that impact on the ability to meet the innovation and clinical objectives of the network. The significant variance in clinical practice between the two trusts could not be supported safely from a single laboratory. Achieving significant benefits from a single laboratory is constrained by the current estate. As such the financial assessment of these factors are significantly less favourable than the two laboratory option. It must be noted that the service review looked at the impact of fully automating the routine processes in microbiology. In the assessment by the review team there was no financial or productivity gains for investing in this type of automation but it did recognise that there are other technological advances in microbiology that could have a positive impact on the productivity of the service. Future clinical alignment may offer an opportunity at a later date for more efficiencies, this recommended option would not inhibit that.

The recommendation of this option does not impact on the cellular pathology or blood sciences options.

Blood sciences: Option Appraisal

Blood Sciences encompasses the clinical disciplines of biochemistry, haematology (inc blood transfusion) and immunology. Blood sciences laboratories and facilities are currently located on all hospital sites:

- Hull Royal Infirmary, all disciplines
- Castle Hill Hospital, biochemistry and haematology
- York Hospital, all disciplines
- Scarborough Hospital, biochemistry and haematology

Blood sciences in general, are high volume services with high levels of automation. The workload is generated from acute sites but also a significant volume from primary care. Low volume specialist testing is carried out on all sites to varying degrees.

Option Name	Description	Advantages	Disadvantages	Scheme objectives and critical success factors
1. Do nothing plus	All services remain in their current	Familiarity with current	Multiple sites leading to duplication of	These two options have been

Option Name	Description	Advantages	Disadvantages	Scheme objectives and critical success factors
	configuration.	system	effort and variation in testing. Does not meet the productivity and efficiency goals of either local HCV partnership or NHSI.	discounted due to the commitment to scale down the blood sciences facilities at CHH. There is no longer a requirement to maintain a laboratory facility at CHH to deliver anything but the acute diagnostics much of which can be provided by the use of POCT devices. The laboratory estate at CHH is located in the Queens centre and provides an opportunity to improve overall blood sciences services. **Discounted**
2. Maintain 4 existing sites but consolidate specialist testing to a single site	All 4 sites remain, with specialist testing distributed to the most appropriate site (which may not be the same site for all tests)	Familiarity with current system	Multiple sites leading to duplication of effort and variation in testing. Very Limited scale of productivity and efficiency goals of either local HCV partnership or NHSI	
3. Maintain 3 full service labs and consolidate specialist testing	Maintain 3 full routine labs and scale back 4th site (CHH) to point of care and limited repertoire automated lab	Retains local GP/CCG services at Scarborough to utilise surplus equipment and staffing capacity required to provide 24/7 acute services to Trust. No risk of deterioration in turnaround time for non-acute users of SH lab Minimally disruptive to current staffing structures in the short term (provides reassurance for staff, hence stability for services. Responsive to the outcome of SGH Acute Service Review	Limits the scale of productivity and efficiency goals of either local HCV partnership or NHSI. Higher staffing levels needed to maintain services based on projected growth in demand	This option has been discounted as the lab at Scarborough does not currently function as a full service lab. The majority of specialist work is transferred to YH. Reverting back to a full service would require investment in staffing and would lead to substantial analytical over capacity. **Discounted**
4. Operate 2 full service labs for routine work with an	Full service routine labs maintained at Hull / York. ASL at	Consolidation of testing increases potential quality	Risk of less attractive lab if no specialist testing performed on-site	

Option Name	Description	Advantages	Disadvantages	Scheme objectives and critical success factors
ASL at Scarborough	third site (SH) and limited repertoire automated lab at 4th site (CHH)	benefit and minimises provision of sub-scale testing, particularly for specialist testing Opportunity to increase utilisation particularly for semi-automated and automated testing, balanced against risk of stranded capacity required for the ASL Consolidation of specialist testing facilitates introduction of new tests in response to demand Specialist test turnaround likely to be improved Consolidation of specialist testing facilitates introduction of new tests in response to demand.	Challenging to maintain staffing pool (& competences) for remaining ASL Loss of connection with research-active clinicians on ASL only sites. Duplication of high volume analytical systems. All labs still require staffing to support 24/7 services	**Preferred Option**
5. Operate Single full service lab for all no urgent specialist and primary care work. ASL at York and Scarborough	Full service lab at 1 site. ASL at sites 2 and 3. (YH, SH) Limited repertoire automated lab at 4th site. (CHH)	Consolidation of testing increases potential quality benefit and minimises provision of sub-scale testing, particularly for specialist testing Opportunity to increase utilisation particularly for semi-automated and automated testing, balanced against risk of stranded capacity required for the ASL	Increases in volume of routine testing for primary care at single lab site may result in longer turnaround times, with more results generated outside of normal working hours. This may impact on clinical OOH cover provided by Trusts and CCGs Lack of flexibility to meet local needs. There is a reduction in resilience to adverse events if reliant on only one	The primary site for this option was identified as HRI due to the adaptability of the laboratory estate and workforce capacity. The review highlighted that the geographical difficulties posed substantial problems that the network would need to overcome to safely move the high volume of primary care work to a hub at HRI. The amelioration of this problem will require substantial transport and logistics changes. There is a risk that the service provision for primary

Option Name	Description	Advantages	Disadvantages	Scheme objectives and critical success factors
		Consolidation of specialist testing facilitates introduction of new tests in response to demand Specialist test turnaround likely to be improved More significant harmonisation feasible when majority of laboratory services operated from single site More feasible to invest in technology at scale where testing volumes are larger (both for specialist and routine) Consolidation of specialist testing facilitates introduction of new tests in response to demand. Ability to deliver high specialist training opportunities for scientific staff.	routine laboratory. Single routine lab would have limited growth capacity and risks from significant geographical distance to new demand in either the south or north Risk of worse turnaround for routine testing due to dependency on transport for full repertoire testing when sharing a single sample All labs still require staffing to support 24/7 services	care practice most distant from the hub would be different from those closer to the hub and would inevitably lead to diagnostic variation contrary to one of the guiding goals of the network. This option still requires substantial staffing and analytical resources to be provided at YH and SH. In the review it is estimated that a minimum 75% of the current WTE would need to be maintained to provide essential 24/7 of 26% of the remaning activity. **Discounted**

Table 5: Blood sciences Options

For blood sciences options 1, 2 and 3 have been discounted. The management teams in the pathology services of each trust have already begun the process moving towards acute service laboratories at SH and CHH blood sciences in response to changes in local circumstances particularly workforce pressures.

Blood Sciences**: Recommended Option**

The preferred configuration for blood sciences is to maintain two routine laboratories at HRI and YH. This option includes the consolidation of specialist work to one of the sites dependent on analytical capacity; this would reduce duplication and includes the consolidation of the immunology laboratory onto HUTH site. The existing services provided at SH and CHH would continue to provide the acute clinical biochemistry and haematology services needed by the respective hospitals, as ASLs. Operating two routine blood sciences laboratories at HRI and YH will provide service resilience and enable impactful service improvements most notably the service's ability to support testing nearer to the patient (point of care, digital diagnostics and devices).The single lab option whilst potentially offering greater levels of efficiencies through consolidated routine work would inevitably lead to lack of flexibility to deliver service improvements across a wider geographical spread, particularly in general practice. The review highlighted particularly the difficulties supporting acute hospitals from large capacity laboratories and showed that the level of laboratory resources needed are near the same level as that currently provided. For example The ASL's that would be set up in YH and SH would necessarily need to maintain sufficient staffing to provide 24/7[11], which would leave the labs over-staffed for the volumes of work processed.75% of the staffing levels would be needed to provide 26% of the current activity.

The recommendation of this option does not impact on the cellular pathology or microbiology options.

Preferred Combined Service Option.

The steering group assessed the combination of preferred and carried forward options to determine if the combined option meets the guiding goals and if the adoption of one option impacts on other departmental options. The steering group looked at the single laboratory options for

[11] https://improvement.nhs.uk/resources/seven-day-services/

cellular pathology and blood sciences to determine if the adoption of one or both would have a beneficial impact on the other departments. It concluded that the preferred combined option for the pathology service would be:

Cellular Pathology: Two laboratories at HRI and YH with shared reporting and specialist testing provided at HRI. Consolidate Microbiology into two laboratories, YH and HRI. Blood Sciences to operate routine work on 2 sites (YH and HRI) SH will operate an ASL for Microbiology and Blood Sciences. CHH ASL providing a small scale haematology and clinical biochemistry test repertoire that meets the needs of the clinical areas and providing a rapid turnaround time in normal working hours. For SH and CHH much of the process to change these laboratories has begun and will be carried forward into 2021/22. Single Immunology and Virology laboratories at HUTH.

Preferred Option: Risks

Risk	Impact	Likelihood	Risk	Mitigating Actions	Residual Risk
Staffing: Staffing risk in the short term may affect the ability to provide robust 24/7 laboratory cover at three geographically distant acute hospitals. Medical staff may consider the option as less attractive and have a detrimental impact on recruitment and	Major with potential risk of disruption to service delivery in some areas or loss of 24/7 coverage, this is particularly relevant for the blood sciences service which	Possible	High	Active HR approach to the organisational changes being proposed. Increased use of Bank and Agency staff to cover staffing gaps. Organisational and cultural development plan (See workforce	Low

Risk	Impact	Likelihood	Risk	Mitigating Actions	Residual Risk
retention. Staffing mobility: lower grade staff are unlikely to move to a new hospital site. This could lead to a short term impact on operational delivery and the timescale in which the scale of consolidation of specialist testing may be achieved and the sustained delivery of 24/7 services.	require 24/7 provision on all acute hospital sites.			strategy). The number of staff required to move to a new hospital site is kept to a minimum (anticipated to be low numbers). Use Locum and bank staff in the short term to fill gaps.	
Transports: Transport issues need to be resolved to prevent degradation in performance. Transport issues need to be resolved to prevent degradation in performance	Major: Inadequate sample transportation leading to failed analysis, detrimental impact on patients, service users and reputation	Unlikely	Medium	Modification and control of current transport system through robust contracting and commissioning. Investment case to be explored for 'bespoke' transport service.	Low
IT: Network Laboratory Information system not implemented, GP ordercomms system not implemented and failure to utilise digital reporting.	Major: Integrated laboratory system and order comms is essential to delivery clinical quality benefits.	Possible	High	LIMS and Digital projects with robust project management. Secure funding.	Low
Laboratory Estate: Service reconfiguration is dependent on the adjustments of existing laboratory estate. YH will require adjustment to permit the microbiology move from SH. Virology at CHH will move to HRI in 2021 to achieve the maximum reconfiguration benefit. Failure to make these changes severely inhibits the scale of service improvements for	Major Failure to provide suitable laboratory accommodation will impact on the effectiveness of the reconfiguration.	Likely:	High	Develop investment cases for the necessary estate changes. Review	Medium

Risk	Impact	Likelihood	Risk	Mitigating Actions	Residual Risk
microbiology					

Table 6 Principle risks relating to the preferred option

Financial Assessment of the Options

Financial Baseline

The financial baseline, also referred to as the As Is Model (Table 9), is the current projected cost base for the Pathology service. This includes inflation and activity growth as per the assumptions set out in the original financial modelling undertaken by McKinsey. The current 2020/21 budget for delivering the Pathology service is £46,814k and this has been used as the baseline for projecting the cost of the service over the next ten years.

Laboratory	Baseline 2020/21 £,000	Yr 1 2021/22 £,000	Yr 2 2022/23 £,000	Yr 3 2023/24 £,000	Yr 4 2024/25 £,000	Yr 5 2025/26 £,000	Yr 6 2026/27 £,000	Yr 7 2027/28 £,000	Yr 8 2028/29 £,000	Yr 9 2029/30 £,000	Yr 10 2030/31 £,000	
Blood Sciences	27,023	27,801	28,614	29,471	30,363	31,243	32,161	33,095	34,048	35,018	36,005	
Microbiology	9,348	9,613	9,887	10,173	10,467	10,766	11,074	11,389	11,709	12,036	12,474	
Cellular Pathology	8,589	8,862	9,138	9,423	9,713	10,022	10,338	10,661	10,989	11,326	11,791	
Central Pathology	1,854	1,955	2,059	2,168	2,279	2,392	2,507	2,630	2,755	2,885	3,139	
Total Costs	**46,814**	**48,231**	**49,698**	**51,235**	**52,822**	**54,424**	**56,081**	**57,775**	**59,501**	**61,265**	**63,409**	
Total Baseline	**46,814**	**48,231**	**49,698**	**51,235**	**52,822**	**54,424**	**56,081**	**57,775**	**59,501**	**61,265**	**63,409**	**554,440**
Net Present Cost @ 3.5% DCF												**535,691**

Table 7 Financial Baseline for the Laboratory Service (As Is Model) over 10 years

The figures above are consolidated at laboratory level using 2020/21 as the starting point. The model projects the baseline, including pay and non-pay inflation and activity growth. In order to calculate the activity growth from the model it has been assumed that the movement in costs less the inflation reflects activity growth and there are no other inputs. As a check, the cost of inflation and activity growth for years one through to five reconciles to the cost shown in the McKinsey modelling as part of the do-nothing calculations between the baseline and the steady state. Any significant changes in inflation and activity would need to be reflected in a future re-model of the As Is position.

Financial Benefits of Target Operating Model (TOM)

The Target Operating Model (TOM), Table 10 below, shows the cost of the preferred delivery options of the collaborative over the 10-year period. The TOM also includes any one off transition costs of developing the collaborative and savings resulting from proposed changes to the management structure. In addition to the projected savings identified in the McKinsey model the figures also include an element of additional procurement savings and workforce skill mix savings that were not factored into the original modelling.

In respect of the procurement savings, there is an expectation that the purchasing power of a large network, combined with a more competitive market place, will likely result in savings on equipment, reagents and consumables. It should be noted that this savings is independent of the TOM but is dependent on the formation of the network to allow greater purchasing power.

Period	Basline 2020/21	Yr 1 2021/22	Yr 2 2022/23	Yr 3 2023/24	Yr 4 2024/25	Yr 5 2025/26	Yr 6 2026/27	Yr 7 2027/28	Yr 8 2028/29	Yr 9 2029/30	Yr 10 2030/31	Total
	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000
Total Pathology	46,814	46,814	48,231	49,698	51,235	52,822	54,424	56,081	57,775	59,501	61,265	**537,845**
Inflation Non Pay		544	563	585	609	609	634	653	667	681	695	**6,240**
Inflation Pay		532	549	580	594	609	626	641	656	672	688	**6,146**
Activity Growth		342	354	372	384	384	397	400	404	412	761	**4,210**
Total Cost of As Is Model		**48,231**	**49,698**	**51,235**	**52,822**	**54,424**	**56,081**	**57,775**	**59,501**	**61,265**	**63,409**	**554,440**
McKinsey Model:												
Procurement (Net of Inflation)		-73	-75	-142	-892	-920	-883	-905	-905	-905	-905	**-6,605**
Workforce		-47	-94	-140	-603	-616	-653	-654	-654	-654	-654	**-4,770**
Equipment		0	0	0	0	-534	-534	-534	-534	-534	-534	**-3,203**
Transport		8	16	138	175	260	260	260	260	260	260	**1,897**
Transition Costs (One Off)		124	114	24	0	0	0	0	0	0	0	**262**
Other:												
Consumable Contracts		-253	-323	-323	-323	-348	-423	-543	-693	-693	-693	**-4,615**
Workforce Skill Mix		0	-38	-93	-135	-135	-135	-155	-155	-155	-155	**-1,156**
Management Restructure		23	-21	-26	-25	-24	-23	-22	-22	-21	-20	**-181**
Emergency Transport Contract		-8	-16	-138	-175	-260	-260	-260	-260	-260	-260	**-1,897**
Activity Cost Avoidance		-342	-354	-372	-384	-384	-397	-400	-404	-412	-761	**-4,210**
Total Target Operating Model		**47,663**	**48,906**	**50,164**	**50,460**	**51,463**	**53,033**	**54,561**	**56,135**	**57,892**	**59,687**	**529,963**
Net Present Cost @3.5% DCF												*512,042*
Comparison of Savings between As Is Model and TOM:												
Notional Saving (Cost Avoidance)		-342	-354	-372	-384	-384	-397	-400	-404	-412	-761	**-4,210**
Actual Cost (Reduction)/Pressure		-226	-437	-699	-1,978	-2,577	-2,651	-2,813	-2,963	-2,962	-2,961	**-20,267**
Total Savings		**-568**	**-792**	**-1,071**	**-2,362**	**-2,961**	**-3,048**	**-3,214**	**-3,366**	**-3,373**	**-3,722**	**-24,477**

Table 8 – Financial Projection for the Laboratory Service (Target Operating Model) over 10 years

The figures are consolidated at a laboratory level from the McKinsey model. Each preferred option by laboratory has been brought together in the TOM table above.

Over the 10 year period there is a calculated saving of £24,477k (4.4%) from implementing the collaborative. This is the difference between what the Pathology service would have cost including inflation and growth under the 'do nothing' scenario, compared to the projected cost following the implementation of the preferred options. Of the savings, £4,210k has been classed as cost avoidance, meaning the service can deal with the level of activity growth through additional efficiencies in the service. With the remaining £20,267k a cashable saving to the collaborative.

Under the As Is model the cost of Pathology at steady state (year 5) would be £54,424k an increase of £7,670k compared to the baseline position of £46,814k. Under the target operating model the equivalent cost would be £51,463k an increase of £4,649k compared to the baseline. The increasing annual cost of pathology is due to the inflationary assumptions in the model. If inflation was excluded the steady state cost of the service would be £44,237k and a saving of £2,577k compared to the baseline.

Other Costs/Efficiencies: Costs and efficiency opportunities that have not been quantified at this stage.

Modification of the current laboratory estate: Moving the microbiology laboratory from SH to YH is a high priority. The Virology Laboratory at CHH will relocate to HRI in early 2021.

The TOM costs for Cellular Pathology are based on the retention of two sites. Laboratory and reporting facilities will remain at HRI and YTH with shared procurements and consolidation of some specialist testing (Option 0 in the OBC). However, should cellular pathology move to a single site laboratory in the future, with digital reporting (option 2 in the OBC), the above figures will require re-modelling as this would deliver further savings.

Medical staffing is yet to be finalised. This will be subject to a consultation exercise, however the outcome does not affect the financial case as either the costs will be transferred to York or a recharge put in place.

The IT workforce modelling savings are not included in the figures and will be updated once this is known.

There is the potential for additional savings arising from the novation of the maintenance contracts into York's LLP. However, any decision to utilise the LLP for contracting needs to be aligned with the proposed changes to the VAT treatment for NHS bodies. At this stage any savings have not been built into the model as it is currently uncertain when the VAT changes will be implemented. This would then remove the opportunity to realise the benefits through using the LLP.

Both HUTH and YTHFT have a number of pathology contracts under MSC arrangements. However, there are a number of services which are not delivered through this contractual route. There are potential further benefits arising from the use of MSC's which will be explored as part of the collaboration. The timeframe for the high value MSC opportunities are shown in the programme road map, Appendix G.

The LIMS replacement plan will provide significant opportunities for operational efficiencies. A fully integrated LIMS and GP order Comms system linked with hospital patient records will offer a wide range of efficiency and productivity benefits. These are detailed in the LIMS PID, in summary: supports demand management, reduce duplication, clinical decision making support for appropriate requesting, introduction of new diagnostics and removal of redundant tests, improved logistics, stock management, business intelligence and health informatics for the whole health system, supports equipment rationalisation, improved TAT, reduced administration and supports interactive communication with service users and patients.

There are procurement opportunities for the collaboration that would provide substantial cost improvements. An assessment of this potential is presented in the section on Organisational Form. Alignment of equipment, reagent and service contracts will provide the opportunity to achieve the economy of scale savings from the combined workload. The future management board will assess the best opportunity to novate contracts or tender for new contracts taking into consideration the potential early exit costs. The future board will employ the range of procurement routes to ensure that the network delivers continual cost improvements without compromising the quality of the service.

Recommendation 1

It is the recommendation of the Pathology Collaboration Steering Board that HUTH and YTHFT boards approve the formation of the pathology network that is configured as described in the combined service option.

A managed distributed service network that reconfigures the current laboratories across the two trusts. It maximises the use of the estate whilst utilising the technology to improve the efficiency and effectiveness of the clinical service.

Cellular Pathology: Two laboratories at HRI and YH with shared reporting and specialist testing provided at HRI.
Microbiology into two laboratories, YH and HRI.
Blood Sciences to operate routine work on 2 sites, YH and HRI.
SH will operate an ASL for Microbiology and Blood Sciences.
CHH ASL providing small scale haematology and clinical biochemistry.
Single Immunology and Virology laboratories at HUTH.
Single management structure for the while network

TARGET OPERATING MODEL (TOM)

The following target operating model will outline how the proposed network will address the case for change and future service resilience.

Clinical Strategy

This section outlines the Clinical Strategy for the delivery of pathology services to Humber Coast and Vale (HC&V) by Hull York Pathology Services. The Clinical Strategy has been developed to meet the challenges and needs of our community and local health economy, taking into consideration:

- **the capacity and demand challenges highlighted in the recent review of pathology services**
- **the changes in technology and diagnostic requirements across England and particularly for the HC&V healthcare**
- **the availability and development opportunities for new diagnostics, new patient pathways and breaking down of traditional boundaries for delivering diagnostic services.**

Our Clinical Strategy provides a framework and direction for the reconfigured pathology services that will ensure the HC&V region has an innovative and sustainable pathology service capable of adapting to the changing needs of clinicians and patients.

This strategy is deliverable in the recommended network configuration.

Clinically led services

Services will be clinically led. This will enable each of the key principles listed below to be achieved through appropriate clinical liaison and with clinical quality and patient safety at the forefront of everything we do.

Key principles:

- The services offered will be necessary and appropriate for the care of our patients, taking into account the specific services provided by each individual hospital and the needs of Primary Care, the Community and other users, such as Mental Health.
- Patients and users will receive equitable access to diagnostic services and clinical advice, regardless of where their samples are processed. Where services are consolidated onto fewer sites to realise the benefits of working at scale, this will only occur when clinical quality and patient safety are not compromised.
- The services offered will support the national and local clinical priorities and support the needs of the local population.

- The clinical provision, services and tests offered will be available equally regardless of time of day/week requested. The service will provide a consistent diagnostic service to meet the standards set out in the NHS Seven day Service Clinical Standards.[12]
- We will be involved in the whole care pathway ensuring that diagnostic testing is evidence based and the test repertoire offered is appropriate and adaptable to the introduction of new tests and removal of redundant tests.
- Where clinically appropriate and effective we will introduce and support the use of diagnostic tests closer to the patient, point of care or smart technology for example.
- We will build stronger links with academic and commercial sectors to ensure that we are in the best position to take up opportunities to be at the forefront of new and innovative diagnostic tests and technologies.
- Clinical teams will link in work with more specialist partners to ensure best outcomes for patients. Links with regional and national centres including (but not limited to) clinical networks, specialist diagnostic referral centres in Leeds and Sheffield, Genomic centres, and PHE laboratories.
- We will be a training centre of excellence for all grades of clinical laboratory staff and support the training and development of clinical staff across the region.
- The service will be guided by national and clinical priorities:

National clinical priorities.

https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

Local clinical priorities

https://humbercoastandvale.org.uk/partnership-long-term-plan/

Primary Care

The relationship with primary care is a key factor in removing diagnostic variation in our healthcare community. The work of the Demand Optimisation Group that has been established in Hull and East Yorkshire and will be extended and enhanced by the addition of representation from the York and Scarborough primary care community. This group has been effective at communicating changes to diagnostic pathways, introducing new tests, monitoring effectiveness of diagnostics and providing a valuable communication link between the pathology services and General Practices. This will be supported by the introduction of a new LIMS and the roll out of a single GP ordercomms system.

The emerging network will provide detailed information to service users, with specific resources for Primary Care aimed at harmonising clinical support to service users and patients. The use of integrated IT systems (GP ordercomms, LIMS and logistic systems) will be used to permit the service to respond in real time to changes in demand on the service and maintain business continuity.

[12] https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf

General Clinical Strategies

- Ensuring clinical quality and patient safety are central to every aspect of the service.
- Maintain the standards required under ISO:15189 for accreditation with UKAS and regulatory authorities, MHRA and HSE.
- Understanding the needs of our patients through continual engagement with services users and clinical colleagues and being responsive to their changing needs and expectations. Providing a service that is flexible to the local needs of service users without compromising the guiding goal of reducing variability of the service offered across the network.
- Harmonise analytical tests offered across the network so there is a single pathology diagnostic catalogue of tests for the region. This diagnostic catalogue will be evidence based and fit with wider regional and specialist services, Genomics for example.
- Harmonisation of Quality Management System across all sites, to include equipment and processes.
- Involvement in care pathways and effective demand management – by working with clinical colleagues to develop and improve patient pathways and ensure efficient use of resources
- Understanding the needs of our patients through continual engagement with service users and clinical colleagues in order to be aware of future clinical developments so that we are in a strong position to influence and support.
- Taking advantage of technological advances as they become available by:
  - building links with research teams in local universities,
  - working with diagnostics companies in the clinical evaluation of novel testing strategies.
- Close collaboration with R&D departments and AHCS networks.
- Clinical liaison and involvement in care pathways – the introduction of any new biomarkers or testing strategies will meet an area of unmet clinical need and are utilised appropriately.
- Maintaining training centre accreditation with IBMS and NSHCS for BMS and Clinical Scientist (STP) training.
- Continuing to develop and maintain links with local schools, colleges and universities to access apprenticeships, NVQs, under-graduate and post-graduate training for existing staff, and to benefit from work-based placements from undergraduate biomedical science students.
- To be involved in provision of training for all grades of students and staff including, but not limited to, Hull York Medical School and junior doctor teaching.
- Repatriate tests referred externally where it is cost effective and does not compromise clinical quality.
- Pursue systems that will allow appropriate data-sharing across health and care services to reduce duplication of testing and to facilitate more joined up healthcare across hospital teams, district nurses, mental health teams, social care staff and other health professionals, Clinical Decision Making tools for example
- Be receptive to supporting the patient pathways from outside our area of operation notable but not exclusively patients on the south bank

Discipline Specific Strategies

Clinical Biochemistry

Clinical Biochemistry 24/7/365 services at three acute hospitals (HRI, YH and SH). Each laboratory offers the repertoire of routine Biochemistry (e.g. U&E, LFT, CRP, glucose) and Immunoassay tests (e.g. cardiac markers, endocrine tests, haematinics) required for an acute hospital. More limited services are provided during core hours at CHH. Samples from CHH requiring more comprehensive testing, and all samples outside core hours, are transported to HRI. SH will also support routine testing for Bridlington Hospital which has no in situ clinical biochemistry facilities.

Centralisation of more specialist analytical biochemistry services at HRI or YH. Rationalise low volume non acute testing to a single site.

Shared responsibility for, clinical services, including clinical laboratory cover, metabolic clinics, and MDTs across all sites.

Haematology

The haematology and blood bank laboratories will provide routine diagnostic tests at four sites HRI, YH, SH and CHH. The routine repertoire of haematology tests includes FBC, coagulation screens, and the provision of matched blood and blood products. The standard full blood count test will be available at HRI, YH and SH 24/7/365. CHH will offer a limited service during the normal working week and will be supported by the main laboratory at HRI. SH will also support routine testing for Bridlington Hospital which has no *in situ* haematology or blood transfusion laboratories. Blood and blood products will be provided and supported using remote access technology which will be extended for use at CHH and other remote sites as appropriate.

Routine blood coagulation testing will be carried out at HRI, YH and SH. YH and SH will maintain the ability to perform factor assays in case of clinical emergencies. Thrombophilia screening will be reviewed but will be carried out on a single site, YH pending the outcome of this review. The haematology laboratory with the clinical haematology teams will extend the current system of anticoagulant testing by POCT or self-testing and reduce the demand on the routine laboratories or need to run hospital based clinics.

The routine haematology laboratories will maintain the ability to carry out haemoglobinopathy screening for Sickle Cell Disease all other screens and identification will be referred to a single site.

The haematology laboratory will develop and implement innovative models of diagnosis and monitoring of patients with anaemia, this will include the use of clinical decision making tools, linking with other diagnostic services (radiology and endoscopy) and clinical teams (dietetics and gastroenterology for example). In order to facilitate the harmonization of haematology diagnostics across the network the laboratory and clinical teams will implement the use of digital blood film reporting.

Immunology

The immunology laboratory will continue to offer a wide range of immunology related tests that will be consolidated where appropriate to a single specialist regional laboratory. It will be clinically led and closely aligned to other clinical teams, in particular clinical immunology & allergy, rheumatology, renal, chest medicine, and haematology/oncology. The clinical support for York will transfer to Hull on the 7th September 2020

This will build on the strong clinical and academic links that the Hull Immunology Laboratory service currently enjoys with HUTH clinical teams & HYMS. Interaction and support for clinical teams at YH and SH that currently have minimal clinical immunology input/liaison will be improved, e.g. through MDTs and pathway/protocol development and optimization, and improved support for primary care.

The laboratory shall operate during normal working hours.

Clinical leadership and supervision of PathLinks Immunology (based in Scunthorpe) will continue from the Hull-York Network. This includes reciprocal support/backup for instrument failures.

A single site will improve service resilience for both the Immunology Laboratory and Clinical Immunology services as a consequence of the concentration of expertise in a single centre. It will also provide opportunities to bring some tests in-house, reducing cost and turnaround times. Consolidation on a single site will improve peer review and support. This is important in ensuring that the network remains at the forefront of improvements in clinical practice in a rapidly evolving area of laboratory medicine.

Urgent ANCA testing will continue to be offered on two sites to minimize turnaround time. Out-of-hours (OOH) availability of immunology tests is not currently required though some limited extended working hours will be needed. If technological advances require availability of OOH immunology tests this would likely be incorporated within Blood Sciences arrangements. This will continue to be reviewed annually.

Microbiology

The microbiology laboratories will offer the wide range of microbiology tests that meet the clinical needs of the acute hospitals and primary care. It is important to recognise that the microbiology laboratory at HUTH has a different medical leadership model to that of YTHFT. The close relationship between medical microbiology and infectious diseases has been developed into a unique and effective department of infection. In this proposal only the microbiology laboratory will move to the new network but the established medical relationship and management model will be maintained in HUTH.

The medical and clinical teams across the network will work to harmonise laboratory practices and through the maintenance of the close relationship with the Infectious Disease service will synchronise the microbiology provision and support the wider regional strategy for infectious diseases, The pathology network in partnership with Infectious Disease will develop a clinical strategy that will take into consideration the following:

- Diagnostic and clinical management advice provided to all hospital services, GP practices and other primary care institutions.
- Remain responsive to new / emerging pathogens / resistant organisms / outbreaks and the appropriate diagnostics for these.
- Liaison with primary and secondary care antimicrobial stewardship teams and drug and therapeutics.
- Microbiological monitoring of the hospital environment, such as theatre air sampling. Liaison with Public Health England.
- Infection prevention and control priorities as determined locally and nationally: support patient management, mandatory reporting, incident management, to ensure that the microbiology clinical team is an integral part of the infection and prevention control team in all partner trusts.
- Antimicrobial resistance as described in the NHS Long-term plan: Ensure laboratory protocols relevant and incorporate stewardship principles and priorities. Focus on providing timely results, including key negative results to allow early cessation of treatment.
- Provide epidemiological data to inform local policies identify and target areas for improvement. Clinicians will need to provide strong antimicrobial stewardship leadership and support the reduction of inappropriate antimicrobial use.
- Support MDT and ward rounds in other specialties such as Infection MDT, ICU, NICU, paediatrics, cardiothoracic, haem-onc.
- CQUINs relevant to infections / antimicrobials: as determined by individual CQUIN requirements and in conjunction with other relevant specialities.

The unique interaction of medical microbiology and infectious diseases will form the basis of a strategic collaboration to explore a regional/ICS Clinical Infection service.

The laboratory will pursue a programme of delivering the diagnostic service by the introduction, where appropriate, of the newly developed molecular and rapid diagnostic technology. The use of automated processing will be kept under review particularly the use of digital imaging tools and methods to improve productivity. Where there are clear clinical benefits, providing a consistent 7 day service in line with the national priorities for example. The strategy will be at the forefront of the development of the microbiology support at SH.

Improved access to blood culture incubation and rapid molecular diagnostics out of routine hours and also same day blood culture sensitivity testing. To ensure diagnostics remain current, clinically relevant and responsive to emerging infections and threats.

Virology

The virus laboratory will provide serological and molecular diagnostic testing covering a wide range of pathogens. The virus laboratory will move to extended working days and weekend working. Service provision will include:

- Viral and non-viral serology, including blood-borne virus and antenatal screening; Occupational Health screening; Confirmatory serology for blood borne viruses.

- Molecular testing including for blood borne viruses, respiratory and enteric pathogens. This includes the support of the HIV and Hepatitis C clinical network. Support the NHS England programme for the treatment and elimination of Hepatitis C infections in collaboration with local Operational Delivery Network through testing, attendance at MDT and provision of data and expert opinion.

- The clinical service will support the care and treatment of patients and particularly the provision of rapid diagnostics where appropriate for respiratory disease, immunocompromised and cancer patients, paediatrics and neonates. Supporting the local needs of the hospital trusts to maintain patient flow, such as improving influenza testing in ED as part of the winter plan. Lessons learnt from the COVID19 pandemic have demonstrated that providing some level of rapid molecular diagnostics for respiratory pathogens is essential to safe patient management and supports patient flow. High volume molecular testing will be rationalised to ensure that there is a resilience capacity to provide this service. Working with the clinical teams and infectious diseases based at HUTH an integrated response to outbreaks and high demand (i.e. flu season) will be agreed.

- Provide a comprehensive screening and diagnostic service for sexual health including supporting community and primary care.

The virology clinicians will support and provide clinical advice across the whole region and work closely with public health and wider regional virology services such as Leeds and Newcastle. Support maternity services through provision of screening services and attendance at ‘HIV in Pregnancy MDT’.

This diagnostic field is rapidly developing; the clinical service will remain responsive to the pace of change in the introduction of new tests, methods and guidelines. The analytical repertoire will be regularly reviewed with service users and we aim to be responsive to their requirements. We also aim to repatriate referred testing where testing volumes and technology allow.

Participation in primary care demand optimisation group and provision of educational material and sessions to improve testing strategy.

Cellular Pathology

The laboratory currently operates during the normal working hours but will remain flexible in order to maintain the flow of work to meet the national and local agreed turnaround times. Clinical reporting is provided and managed with agreement of the medical staff in their job plans.

The laboratory and reporting systems will be harmonised across the network:

- Digital pathology: use of whole slide imaging to allow cross-site MDT review and cover; cross-site sharing of reporting capacity; fast tertiary centre MDT and specialist second-opinion review; allow robust and governable programmed and extra-contractual reporting from home; facilitate efficient out-sourcing of triaged cases.

- Provide fast clinically relevant reporting of diagnostic specimens to support national cancer treatment targets and cancer screening programmes.
- Provide rapid access to non-gynaecological cytology services to support one-stop clinics and clinically urgent cases.
- Develop specialist testing capacity (e.g. PCR and specialist low volume immunohistochemistry for targetable tumour mutations), reducing expense and delays in out-sourcing this work.
- Integrate our tissue pathways with fresh frozen tissue sampling requirements to feed regional genomic centre (Leeds).
- Unified approach to organising pathologist reporting (i.e. all pathologists reporting a minimum of three specialist areas, as opposed to generalists or single/dual specialisation). This will facilitate more cross-cover and greater service reliability.
- Make best use of and expand advanced practitioner roles in line with RCPath and IBMS guidelines and curricula.

Acute Service Laboratories (ASL)

The recommended option for the Hull York Pathology Service includes the provision of an Acute Service Laboratory at SH and CHH. The definition of the ASL for HYPS is a combination of the guidance from NHSI[13] and from the service review. The principles of the ASL are as follows.

- The facilities provided in the ASL will be at a minimum to support the clinical services being provided by the acute hospital in which it is located.
- Providing analytical capacity that balances gaining the optimum efficiency from the analytical instruments with enough capacity to support the acute services without the need to export the work to the routine laboratories
- Point of Care systems in use must be supported and compatible with the instruments in use across the network and connected to the wider information system.
- Remote clinical advice facilitated through good LIMS.
- Opportunities for staff to rotate in/out of the ASL

The ASL provision in SH will be different from CHH.

SH will be required 24/7. A critical factor in the services offered at the SH ASL will be the need to ensure that patient flows are not impacted on the lack of pathology provision and that the services provided will be reviewed as the recommendations following the acute service review are taken up.

CHH will be required for the normal working week and will adopt the use of POCT to a greater extent. The key element of the tests offered will be meeting the rapid turnaround time of results required by the Queens Centre, Cardiothoracic and Intensive care units.

	Clinical Discipline			
	Clinical	Haematology	Microbiology	Point of Care

[13] https://improvement.nhs.uk/documents/2366/Template_structure_for_ESL_blood_sciences_RE03.pdf

	Biochemistry			
Test repertoire	Routine test repertoire that meets the agreed user TAT with service users.		Utilise rapid diagnostics methods as appropriate	Extend current provision subject to meeting quality standards
	Range of biochemistry tests necessary to support the acute services in the hospital.	Full Blood Counts, routine coagulation testing and provision of blood and blood products for transfusion.	Tests required to support acute hospital services with rapid turnaround: Bacteriology - Blood culture Molecular microbiology – rapid viral detection (e.g. respiratory)	Range of approved tests that are accepted as essential to support patient care where there is necessity for rapid results to manage clinical care or avoid additional or duplicated clinical procedures i.e. attending hospital clinics
Equipment profile	The equipment profile will be configured to ensure that there is adequate capacity to meet expected demand, there is sufficient resilience for business continuity (for system failures over 0-48hrs), minimizes manual testing processes, automated processes that are suitable for non-registered practitioners, biomedical scientist and ,multi-disciplinary biomedical scientists and minimum advanced/expert practitioner intervention.		Rapid diagnostic platforms and blood culture incubation.	Set of labs with common semi-automated or manual platforms **Point-of-care testing**: automated standalone bench top analyser able to be operated by non-registered staff and remotely monitored/supported by qualified laboratory staff
Staffing profile	Staff required: HCPC registered Biomedical Scientist (BMS) Support staff (bands 2-4) Staff may be single-discipline or cross- discipline Numbers of registered staff required depends of workload and workflow across 24/7 Note that the distance between each acute site requires a site-specific workforce of sufficient numbers, qualifications and skill-mix to staff a 24/7 rota. *Clinical scientist / medical support (may be provided remotely)*		Does not require traditional speciality microbiology skill-set May be undertaken by Band 4 associate practitioners overseen by suitably cross-trained registered scientists	Suitably trained clinical staff, (not necessarily biomedical staff) i.e. nursing, support workers or medical staff. Support and service supervision provided by registered scientists (remotely and on-site).

		Supported remotely from main lab(s)	

Table 9: ASL outline specification

Workforce Strategy

This section outlines the strategy for the pathology workforce for the Hull and York pathology services. It will outline the key principles the workforce reconfiguration will follow. Taking into consideration the local, and national workforce challenges and the capacity and demand challenges highlighted in the recent review of pathology services.

This document sets out the recommended workforce structure across the network that will ensure the pathology services can maintain high quality service delivery and be able to take on and develop a fulfilling, innovative and progressive workforce plan for the next 10 years. The strategy will take into consideration the availability of all staffing groups including the national expected rollout of trainees from scientific and medical training programs. Changes in technology and diagnostic requirements across England and particularly for the Humber Coast and Vale healthcare partnership will be a guiding principle behind proposed workforce plan. New roles, different routes of entry, flexible working, and the breaking down of traditional boundaries will be considerations in this strategy. We will be removing the traditional boundaries for scientific, clinical and medical practitioners in order to create flexible, adaptive and fulfilling roles across all grades and disciplines in pathology.

Pathology services undertook a review of the current services for HUTH and YTHFT the output of which was evidence based assessment of future service configuration options. Key findings from this review highlight important effectors on the future workforce of the service

- **Growing demand and increased test complexity**

Sample growth is projected to grow from current levels by 6% by 2022/23, test growth is predicted to grow from current levels by 15% by 2022/23.

To meet this demand and mitigate the escalated staff costs the workforce plan develops BMS staff into new, specialist and advanced fields and at the same time utilise automation that can be used by non-registered staff. Growing the number of non-registered staff would also provide the base for our staff to develop into BMS's and Clinical Scientists as per figure 4.

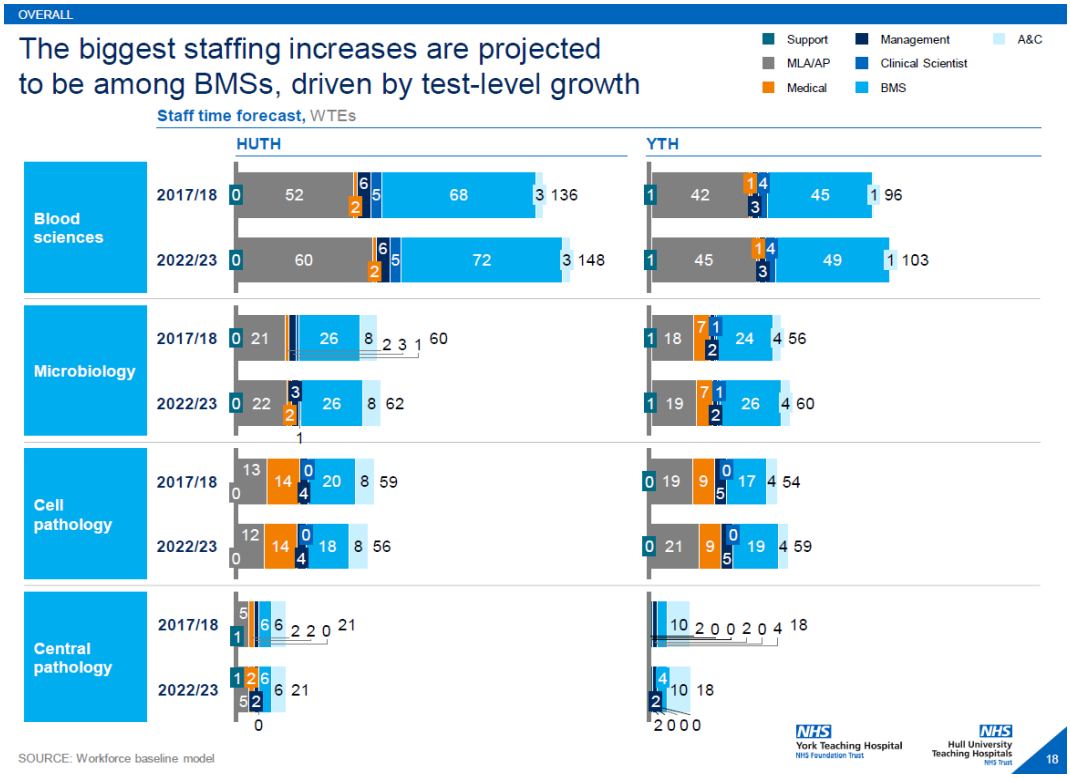

Figure 3. The workforce predictions upto 2023 based on 'do nothing' option and shows the impact on the workforce if we maintain our current system of working.

- **Increasing cost of new technology**

Technology is moving rapidly in several areas of pathology, driven by competition between suppliers to develop products which enable faster and more accurate results with greater efficiency. These developing technologies will require a workforce that is adaptable and flexible to meet the technical challenges as well as clinical expertise to utilize these emerging diagnostics. This rapidly developing area will require:

- Staff skilled in the use of the new genetic or molecular technology. The COVID 19 pandemic highlighted the need to have a wider range of BMS staff that have developed the skills and expertise in molecular techniques.

- Improved automation- Automation within blood sciences has been common, but the technology is improving and the automation of microbiology labs is now starting to offer greater benefits. Overall the cost effective availability of analytical systems is driving the skills mix in large laboratories, more band 4

and 5 staff needed, releasing band 6 upwards for specialist/advanced practice.

- Digital technologies - Digital pathology is at a much earlier stage of development than digital radiology but will require new skills for clinical and technical staff and changes in IT support

- Extending the use of point of care testing (POCT) – the pathology workforce will need to develop to be manage this direct patient facing aspect of the service.

- The ASL's will make use of rapid, molecular and POC tests in multiple laboratory disciplines. Staff in the ASL's will need multidisciplinary training.

One key learning point from the COVID-19 pandemic is the need for BMS staff to be able to work across the discipline boundaries and the development of roles that encourages multidisciplinary working, "molecular biologists" and "serologist" for example. We will aim to have 10% of the BMS staff with skills that can cross over into these and other specialist areas so that the burden of meeting any future national health challenge does not fall on a small or single cohort of scientific staff.

- **Sustainability of Services**

Nationally there are difficulties in the recruitment and retention of highly specialised and skilled staff in particular Consultant Histopathologists, but also consultants and biomedical scientists across a range of sub-specialties. Consultants in pathology have an older than average age profile and posts have been unfilled for several years. This on-going situation can lead to delays in diagnostic results or excessive locum and agency costs.

Recommended Option Workforce Impact and Benefits

Impact

The impact of the recommended reconfiguration option will be that in the main few staff will be needed to relocate in the short term. The exception being that the senior management teams will be required to operate across the network.

It is expected that non-medical staff employed by HUTH will TUPE transfer to the Host body (York) following a period of formal consultation. With regards to the medical staff it is envisaged that a similar formal consultation process will take place concerning the assimilation of all clinical staff into one organisation (the host). The outcome of that process is less certain but the intention is that all clinical staff will be job planned by the senior management team and that there will be uniform management of the clinical services across the network from a terms & conditions perspective. All Future appointments will be made by the host Trust

The impact of national shortages in medical staff represents a critical risk to service delivery and financial challenge to provide bank/locum staff.

Benefits

The benefits for the workforce of the recommended option will be:

- The size of the new organisation will offer more dynamic and diverse roles, across sites, in bigger teams, with broader and more challenging work placements.
- The variety of working environments, large lab through to ASL will support the development of new skills and provide staff with opportunities for different career pathways.
- There will be planned developments and opportunities to introduce and use expert and advance scientist roles to replace and/or underpin medical consultant posts.

Workforce Strategy: Our Vision for the Future

As a collaborative our aim is to deliver the highest quality, sustainable and affordable pathology services across the healthcare system.

At the core of HYPS is the focus on creating high performing operational clinical teams that achieve the best outcomes. The standard shall be to provide the right test, at the right time, provide the right result and add that it should be carried out by the right staff. This will be delivered in an environment that supports the workforce in their personal and professional development, making the service a desirable employer of choice both locally and nationally.

The ethical and professional standards laid down by the HCPC, NMC and GMC will be upheld alongside this strategy and will take into consideration the needs of individual registrants to keep meet these standards. Non-regulated staff groups will be encouraged to abide by the attitudes and behaviours' of the wider NHS.

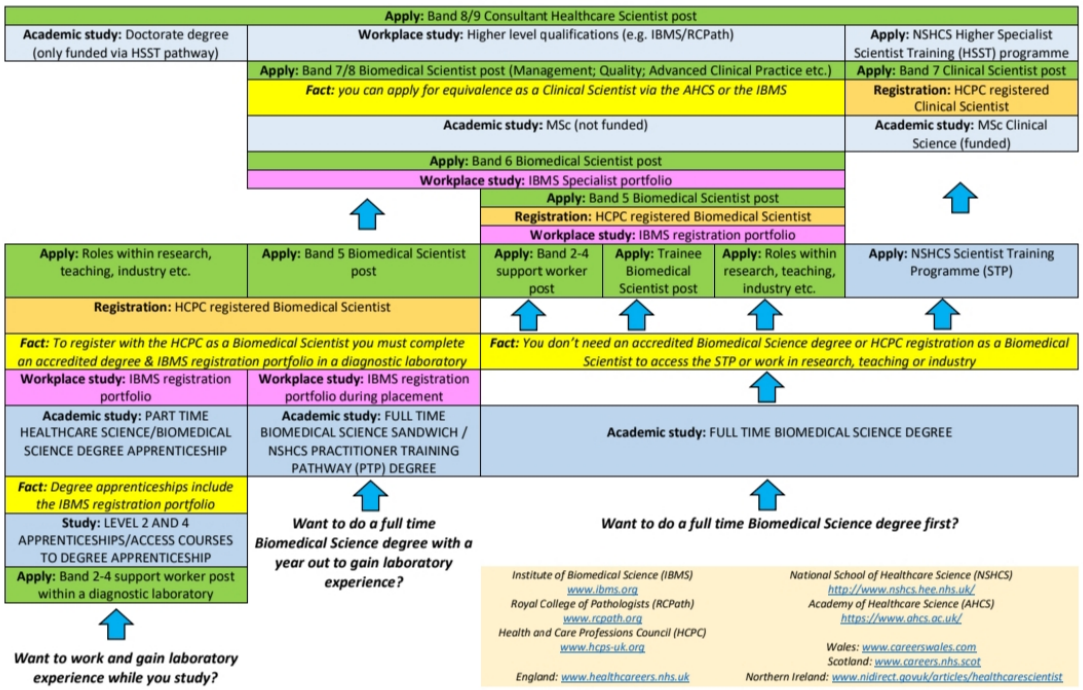

Figure 4:
Healthcare Scientist Training Pathway

Medical training capacity demand and future needs

The training capacity, demand and future need will be assessed as part of the workforce plan. See workforce impact above. Particular focus on:

- Consultant Histopathologist establishment will be supplemented with consultant and advanced BMS practitioners.
- There are constraints on recruiting medical microbiology staff as a result of the changes in training pathways. Future workforce supply is not assured. The relationship between microbiology and infectious diseases will provide opportunities to cross train medical staff in infectious diseases and medical microbiology. The medical establishment in microbiology (and virology) will be supported with consultant and advanced BMS practitioners.

As part of the management plan for the creation of HYPS there will be an organisational development strategy that will manage change and introduce new ways of working for clinical and managerial teams to support the model of service the trusts aims to deliver.

Strategic approach

- Establish a common grading and role structure across the partner trusts. Including common job profiles and job descriptions are transferable across the network.

- Develop cross disciplinary/multidisciplinary flexible workforce particularly for biomedical scientists and support staff.

- Develop flexible working across traditional medical and scientific boundaries in particular the use of consultant scientist posts and advanced practitioners scientist posts.

- Establish clear training and development pathways for non-clinical and scientific staff in particular the route for support workers to enter healthcare science career pathway.

- Establish new roles in health Informatics across the network.

- Build relationships with educational establishments for young adults entering the workforce.

- Utilise the apprenticeship levy.

- Develop expertise in delivering innovative training and establish a centre of excellence for healthcare science.

- Supporting training and development for non-laboratory staff in the use of diagnostics and particularly point of care testing.

- Establish close links with higher educational institutions.

- Explore flexible working and potential for staff movements across the challenging geography that the network presents.

- Detail the workforce strategy for each staff group.

Organisational development strategy

The OD strategy will be a key enabler in achieving HCV ambition and delivering the benefits as presented throughout this case; its implementation is crucial to the success of the new organisation and will be developed in partnership with stakeholders and staff. Once developed the OD strategy will provide:

- A shared vision, values and purpose of the organisation, embedded and understood through a culture which respects everyone's time. A shared vision, underpinned by values and behaviours that are embedded and understood by all and provide the opportunity to develop a unique identity for the service.
- Strong board level leadership, visible and closely connected to the rest of the organisation
- Strong clinical leadership and organisational structures that deliver the vision and principles of the organisation
- Highly engaged and supportive stakeholders, including staff, patients and carers, the public and members.
- A highly performing workforce who understand and buy-in to their personal role in delivering the vision/strategic aims.

- Creating career development opportunities through an effective talent management program, succession planning, grow your own programs and connections with schools and education providers across the communities.
- An understood and trusted employer brand based on high level of staff and patient satisfaction and engagement.

Developing the OD Plan

The HYPS Board will oversee the development of the OD plan and ensure accountability for delivery; with a vital role in shaping the culture, behaviours and values and in challenging actions and activities which do not support it.

The strategy will be developed using the principles and phases set out in the NHSI Culture and Leadership toolkit. Following the completion of the service review; the next stage of engagement activity is planned with staff and key stakeholders to understand what matters to them and what further needs to be done to achieve a cultural identity for the new service network.

Managing people through change

The senior management board and team will undergo at an early stage training and development to help them deliver the complex and difficult transition to the new network.

Developing organisational structures

The structure of HYPS will support the development of a strong leadership and accountability culture. In developing plans for HYPS, a number of design principles were agreed to guide and drive consistency in the development of the ‘to be’ organisational structure The organisational structure is a key element of the future operating model and the organisational design principles are aligned with and support the sponsoring trusts.

Harmonising employment terms and conditions

Within the workforce programme actions have been identified to highlight variations in the terms and conditions for employees. There are inevitably some areas where, for example grading of posts apparently with equivalent duties is not consistent between the two organisations. In particular arrangements for additional duty payments for additional sessions at weekends, shift payments and pay protection are different. These issues will need to be addressed early to establish a consistent approach.

Management of people transition

All organisational changes will be made through application of best professional practice and in line with the relevant employment legislation. The consultation requirements for TUPE and any potential redundancies or redeployments will be in line with the legislative requirements and the policies of both organisations. Every effort will be made to minimise any staff redundancies. Where people are displaced workforce professionals will work with them to find suitable alternative positions, including, where feasible, on the job training.

Throughout this process, there will be active and consistent partnership working with recognised Trade Unions and, where appropriate, other staff representative bodies.

Transfer of Undertakings (Protection of Employment): TUPE

This area will be guided by senior HR teams and will be reviewed as part of the agreement on the future legal status of the service.

Education and training

New faculty

Currently, responsibility for education and training is dispersed across different departments within HUTH and YTHFT. There are notable areas of high quality and innovation, such as the development of advanced practitioners, supporting students on the scientific training program and the utilization of the apprenticeship levy. However, the quality of education and training in other areas, the lack of career progression and development opportunities reported in exit interviews at both organisations are likely to be contributors to the on-going recruitment and retention challenges. It is the intention that the new service will create a faculty of education and training with dedicated senior leadership, to support the professional, clinical and leadership skills within HYPS. The faculty of education and training will:

- Raise the quality, consistency and scope of the education and training available to all staff
- Develop a culture of lifelong learning, with the goal of all staff in education or training throughout their career
- Position the new organisation as a preferred destination for staff
- Create strong partnerships with universities, medical schools and other existing education providers
- Become accredited to provide training and development in pathology disciplines that may be accessible to the wider region.
- The creation of new staff roles and development opportunities for staff in all groups

Practical Support

Recognising that change can be challenging, all staff will continue to have access to internal and external independent support. Those leading the organisational change are being offered change management and people leadership training and development.

Infrastructure and Enabling Strategy

Estate.

HRI: the main pathology building at Hull Royal Infirmary is a relatively new facility. The ground floor houses the blood sciences department and cellular pathology is on the first floor. Office and administrative accommodation is distributed throughout both floors. A significant area of ground floor is set aside for stores. The stores and office accommodation is suitable for development into laboratory space. The microbiology laboratory is located in the east side of the first floor tower block. This accommodation is split between laboratory and office accommodation and hosts the decontamination autoclaves and category three biohazard handling room. This accommodation requires substantial refurbishment to make it fit for purpose beyond the next 3 years.

CHH: the combined blood sciences laboratory is located in the Queen centre. This is new accommodation and is highly adaptable as laboratory space. The virus laboratory (virology) is currently located on the Castle Hill site. During the COVID19 pandemic it was clear that the existing building could not be used for very high volume molecular and virology testing. . The virus laboratory will relocate to the main HRI site in early 2021. This new facility will provided fit for purpose laboratory accommodation for molecular diagnostics and will support the growth of this technological area for the wider pathology network .

YH: the laboratories at York Hospital are located on four floors of the main building. Ground floor houses specimen reception, first floor microbiology and non-gynae cytology, second floor blood sciences and the third floor cellular pathology.

All areas are mixed laboratory and office accommodation. Autoclave and the Containment Level 3 facility are located on the microbiology floor. Most areas are constrained for space particularly Cellular Pathology following the relocation of services from Scarborough hospital. Outline plans are available to extend the third floor accommodation. In general, the accommodation requires refurbishment and modifications to ensure it is fit for purpose in the future configurations. The response to the COVID 19 pandemic required the microbiology laboratory to modify its use of the available space, this will need to be reviewed and a permanent solution developed that will give the YH laboratory effective molecular testing environment.

SH: the Scarborough laboratory accommodation is adjacent to the emergency department. Laboratory accommodation is currently in use on the ground floor for blood sciences and limited use on the first floor microbiology. There is vacant accommodation due to cellular pathology services relocating to York. This accommodation requires extensive modification and refurbishment to ensure that is fit for purpose for the next 2 years. There is an existing proposal to relocate the laboratory to a vacant ward (Haldane).

Laboratory Information Management System (LIMS):

The implementation of a single LIMS is essential to the successful consolidation of testing across the two trusts. Key benefits are outlined in the LIMS project plan and business case.

Transport

Increased frequency of trunk route transport between the 4 lab sites will be required to enable consolidated testing laboratories to meet turnaround targets – the frequency of these has been modelled. Shift in timing of local transport from GP to lab 'collector' sites (and potentially therefore additional runs from the fixed hospital transport currently used) will be required to level demand on the laboratories in all models and to enable turnaround times to be met in consolidated models that rely on onwards transport along trunk routes
New transport will need to be able to handle:

- The full range of specimen types:
- Surgical specimens (in appropriate transportation systems)
- Potentially infectious samples (potentially post-culture, increasing infection risk)
- A full range of transport conditions
- Controlled room temperature for analyte stability
- Frozen for analyte stability
- Potentially mid-incubation for microbiology samples in order to minimise delays to turnaround time

Samples will be processed and booked in at collector sites to enable better sample stability and tracking; live tracking of transport vehicles would be an essential specification to improve visibility of demand timing and enable better matching with capacity (either re-routing towards laboratories with capacity or shifting to 'surge staffing' in e.g. pre-analytical areas). The HYPS Board shall undertake a feasibility study for the best approach to achieve this.

FINANCIAL CASE

Financial Case baseline

The service review detailed the current capacity, demand and financial position of the two current services. It followed this up with detailed projections of activity, capacity, workforce and finance up to 2030/31. The baseline year for the work undertaken by McKinsey was 2017/18, however as a number of years have passed in developing the collaboration the financial baseline has been reset to use the 2020/21 budget for both organisations. Detailed report on these projections is attached in Appendix H.

Management structure

It is proposed that the Pathology Collaboration would take the route of a joint venture between Hull University Teaching Hospital NHS Trust and York Teaching Hospital NHS Foundation Trust, which by agreement would be hosted by one of the Trusts. The 'Hull York Pathology Service' (HYPS) would be led by the HYPS Management Board, and would be accountable to the respective partner Trusts for the performance of the Pathology Collaboration.

Financial Model – Summary of Approach

The following provides an outline of a suggested financial model that will support the work of the collaborative.

The model assumes that:

- Staff in the non-host Trust would TUPE transfer to the host organisation. Any residual costs to be shared equally by the two Trusts.
- The non-host Trust would charge the host Trust for the use of its laboratory facilities on a fully absorbed cost basis.

For the purposes of the model, it is suggested that the HYPS be treated as a separate trading entity by the host Trust. The host Trust would adopt and develop a trading account approach built around the idea of the trading entity, both for planning and in-year actual trading. A principle will be that the trading entity would collect all fully absorbed costs of operating the collaborative and then charge users, including the host Trust, for services received. The trading account would be the main vehicle for reporting performance through to the HYPS Management Board, and onward to each respective partner Trust Board of Directors.

An annual plan will be established based on planned activity for all customers (both Trusts, GPs, others) from which the fully absorbed cost of operating the collaborative as a trading entity would be assessed.

A common pricing model and strategy will be developed and agreed. The strategy will form the basis of the recharge (equating to collaborative income) to users of the service (both for planning and actual trading purposes), including the partner Trusts, based on a cost per

case basis for activity. Due to the potential volume of work a cost per case approach consideration could be given to a cost and volume model for trading with the Trusts. It is envisaged that services to GPs and other organisations would remain on a cost per case basis. It is likely that if a cost and volume approach is chosen, actual activity monitoring would still be required to support this approach as it would for cost per case.

Consideration may also be given to activity level triggers whereby if actual activity is above/ below planned levels by a prescribed percentage, a reassessment of prices may be necessary, particularly for the partner Trusts.

The planned income and expenditure for the trading entity will also most likely include an efficiency requirement (or trading profit target) agreed by the partner Trusts. A risk management arrangement will need to be agreed between the partner Trusts where actual events result in favourable/ adverse variances from plan e.g. activity above/ below plan, unforeseen cost pressures, etc.

It is recommended that early testing and scenario modelling of the proposed plan against each Trust's current performance is undertaken in order to highlight any unforeseen adverse impact on either Trust's current baseline. This should allow early identification of issues that may require mitigation within the overall financial model and trading account, so that neither organisation is initially disadvantaged by moving to this new collaborative approach; for example York Trust benefits from high levels of contribution from GP work, which it would be looking to protect in any new arrangement.

Recharges

As described above, full income and expenditure of operating the HYPS will be managed as a separate trading account

As discussed above, recharges using an agreed pricing methodology, to all service users (including partner Trusts) would be based on a fully absorbed cost per test basis linked to actual activity, although there may be a differential pricing strategy for the Trust as distinct to other customers.

Transition Costs

It is anticipated that there will be short term costs relating to the transition arrangements from the current to proposed structures, which ideally will be identified upfront; built into the annual plan, and shared equally by the partner Trusts. Where transition costs arise in year and are not recognised in the annual plan, it is suggested that these are split equally between the partner Trusts unless the origin and nature of the costs suggests otherwise, and as long as they are agreed through to the HYPS Management Board prior to being incurred.

Voting Rights

Whilst the collaborative would be hosted by one Trust, each Trust would be represented on the HYPS Management Board. The representation and voting rights will need clarifying, but

in the event of the HYPS Management Board being split on a key decision, this will be escalated to the HYMS Oversight Board for decision.

Corporate Services/Access

The HYPS will require access to corporate services such as Financial Management, HR, Payroll, Procurement, etc., which will be provided by the host Trust. The new service will also have access to YTHFM LLP. The cost of providing these services will be included in the annual plan possibly as a fixed annual charge to the HYPS by the host Trust, and covered through the pricing mechanism to all users for services received.

Profit and Loss

As part of the annual planning process, an agreed income and expenditure plan with a resulting profit (or loss) will be agreed by the HYPS Management Board and the respective partner Trust Board of Directors. It is likely that a profit will be agreed as a result of both Trusts prescribing a common and agreed efficiency improvement of the Pathology Collaborative. Any actual profit/loss at the year-end would be split equally between the two Trusts. Progress against plan would be monitored throughout the year, with balancing invoices/credits raised quarterly to avoid unexpected charges at year end.

Budgeting/Planning

The annual planning process employed by the host Trust will mirror the timetable for clinical activity and other planning processes within the partner Trusts. Pay and non-pay budgets will be set to take account of current pay and non-pay inflationary predictions, and relevant activity and other information available at the time. These will form the basis from which prices are established in support of the annual plan and agreed by the HYPS Management Board and each partner Trust Board of Directors prior to the start of financial year.

Scheme of Delegation

The collaborative will operate in line with the host Trust's Scheme of Delegation, as amended where necessary to reflect the unique nature of the collaborative. The Pathology collaboration Medical Director and Director of Operations will be identified as the prime budget holders for the purposes of the scheme of delegation, but with authority to delegate authority to other officers within the collaborative management structure.

Accounting Principles

Monthly financial reports would be produced by the host Trust's management accounts team and made available to operational teams. In addition, the monthly trading account will be produced and made available to the HYPS Management Board, and each respective Trust Board of Directors. The cost centres will need to be within the ledger of the host Trust allowing feeder files such as payroll, AP, AR etc., to be fed into the monthly reports.

Capital Investment

The HYMS Management Board will have responsibility for ensuring that there is a robust rolling equipment replacement and investment programme in place; that seeks, where appropriate, to harmonise equipment used over the different sites in order to maximise procurement efficiency opportunities. These will need agreeing with each partner Trust Board of Directors, and incorporating within the annual plan.

A creative approach to resourcing the new and replacement equipment programme will be adopted, including where appropriate a managed service approach will be adopted where this is deemed to be more advantageous. Where funding by capital investment is required, as activity may be undertaken at any site for each Trust, a more collaborative approach to resourcing capital may need considered by the two Trusts including due consideration of service demand by each. Any applications would still need to go through the respective Trusts capital approval processes. Other sources of capital investment such as HCV HCP alliance funding should be sought by the collaborative wherever possible.

Staff (TUPE) and Contracts

It is understood that under the hosted joint venture, all Pathology staff will be employed by the host Trust, and those employed by the non-host Trust will TUPE across to the host Trust. In some instances, this may lead to relocation and the HYPS Management Board will need to be aware of the likely TUPE redundancy costs that this may bring, and how this may reduce the savings sought by the collaboration. It is recommended that, with HR support, a careful plan of redeployment is entered into by each Trust with the aim of minimising any redundancy costs. Any residual costs would be borne by the collaborative as part of the transition costs. The process of transferring staff across to the new host will take place in the 6 month transition period following the approval of this case.

SLA/ Contract Monitoring/ Customer Contracts

Regular contract management meetings will need to be in place in order to ensure no unforeseen charges are received by each Trust and also that demand management is monitored to ensure income is being received at expected levels for all non-NHS and other providers.

Another key part to this will be contract monitoring with relevant CCG's, the setting up of this joint venture can't financially jeopardise either Trust, and where Direct Access charging was providing a surplus for either Trust this must be reflected in financial management of the joint venture.

The preferred way forward is that prices are harmonised across the joint venture and designed to cover the full actual cost of delivering the collaborative to each Trust, and this shouldn't financially jeopardise either Trust given the current fixed contract with commissioners. Issues may only arise with peripheral CCGs and any cross border work by York for East Riding GP's or Hull for VoYCCG GP's where income could change but this should only be minor in relation to total Direct Access income.

It is proposed that ultimately all direct access contracts will be held by the host Trust. All current contracts will be subject to novation; whereas all new contracts will directly with the host Trust, with the proviso that neither Trust should be financially disadvantaged with regard to the benefits derived from the current contracts.

Trading Accounts

Trading accounts will form the prime basis through which the HYPS Management Board and the respective Trust Board of Directors will monitor the performance of the collaborative. They will facilitate contract monitoring meetings between the Trusts allowing the monitoring of activity levels and emerging cost pressures. Corrective action may then be agreed, and where necessary the management and burden of residual risks agreed between the Trusts.

Pricing and Costs

The first major piece of work once the Pathology Collaborative is set up will be to agree a pricing strategy; and harmonise prices between the Trusts. The key mechanism to support this will be the installation of the new LIMS system and will combine price structures across all sites for every test provided by each Trust. Without the LIMS system, achieving this will be very difficult and interim arrangements will need to be devised.

The principal for the harmonisation of prices will be for every test at York, Scarborough, Castle Hill and Hull to be priced the same, ie no HCV service user variance. The pricing strategy will then need to determine what uplift is applied for CCG's (noting the fixed nature of some CCG contracts), other NHS Bodies, Non-NHS SLA's, Private Patients, Insurance Companies etc.

Transfer of Assets/ Asset Management

Current Assets (primarily Stocks)

Non-host stocks to be sold to the host Trust at cost.

Fixed Assets

Non-host Trust laboratory buildings, plant, and non-clinical equipment that are still to be used as part of the HYPS operational model will be retained by the non-host Trust, and a lease charge will be made to the host Trust.

Clinical equipment acquired through a management services contract, or where independently leased will be transferred to the host Trust, through the novation of the respective contracts.

Where clinical equipment has been purchased by the non-host Trust, this will be sold to the host Trust at net book value, and shown on the host Trust's balance sheet.

New/ replacement assets would sit on the host Trust's balance sheet linked to the programme of replacement agreed by the HYPS Management Board and by each Trust's Board of Directors.

ORGANISATIONAL FORM

Legal Structure

As part of developing the case for the pathology network, the collaborative sought advice on the possible organisational form the network might take. The programme team examined information and guidance provided by legal teams, NHSI and from other established pathology networks on the criteria on which to evaluate the most favourable organisational form[14]. A joint venture was agreed from the outset as the most appropriate fit for the new network. The focus of the assessment was two possible approaches to setting up a new joint venture:

A **corporate** joint venture, which is a joint working arrangement that uses the formation of a separate corporate vehicle, for example: a company limited by shares or guarantee (LLP type vehicle), or a community interest company. The corporate joint venture would be a separate entity from the two trusts and would be required to obtain all legal registrations and accreditations in its own name. Each trust would have an equal share in the joint venture.

or

A **contractual** joint venture, which is a form of contracting between the parties that does not use a separate vehicle. The contractual joint venture will require the two trusts to agree who would be the prime contract holder, (the host), a board with clear terms or reference, authority, role, structure and constitution will be required and there would be contractual arrangements in place between host and partner trusts which will set out the services being undertaken.

Recommendation 2a

It is recommended that a **Contractual Joint venture** with one of the trusts hosting the service.

This would involve a single host organisation contracting for all the relevant services comprising the pathology network on behalf of both trusts. Based upon:

- Practicality of forming the new body now and delivery of future service options.
- Avoids high cost of setting up corporate vehicle.
- Avoids potential conflict in respect to workforce challenges.
- Services lack the experience and expertise to manage a new corporate vehicle without significant development and support.
- Reduces the risk of legal challenge in respect to market share and competition.

[14] NHSI Guidance note

This form is suitable where all parties are NHS bodies and does not involve the creation of a new legal entity. It involves the full integration of all pathology services to create an organisation hosted by one of the trusts but serving all trusts.

This structure allows for a responsive service that is well-defined and where the operational management team has full control of operations at all sites. This means it has greater leverage to optimise the effectiveness and efficiency of the service and implement change. Each trust retains clinical influence through the clinical leadership represented on the oversight committee, the management board and HCV Clinical Advisory Group. (see Management case). Equally, strategic control is retained by all trusts through the network oversight board where all trusts have representatives and voting rights. The operational management team will operate in accordance with a well-defined scheme of delegation.

The host would manage the prime contract in accordance with the joint venture agreement that the parties enter into, and sub-contract relevant services to the other party.

Regardless of the host of the contractual joint venture, the documentation underpinning the joint venture will set out the rights and obligations of each of the parties and includes those principles covered in the finance and management cases.

It would operate under a quasi-autonomous regime with its own management board with reporting requirements to the host trust. These reporting requirements would be defined by an approved Scheme of Delegation that would be part of a contractual Joint Venture Agreement between the parties (outlined in the Finance case)

Hosting

In determining the host, the steering board considered the range of criteria that the hosting organisation would meet in order to provide the most beneficial arrangement for HUTH and YTHFT

The criteria themselves were assessed with the following principles in mind:

1. That the host trust should not be disadvantaged as part of the hosting agreement, and that both stakeholder trusts commit to equal share as outlined in the Finance case.
2. That the choice of the host maximises the potential financial savings in the short, medium and long term.
3. That the choice of host does not impact on the ability of the network to deliver its full range of services now and in the future.
4. Hull York pathology service will be managed by an appointed management board that will be accountable to an oversight committee as part of the standing committees of HUTH and YTHFT. The oversight committee will have equal representation at executive level from each of the partner trusts and will be chaired by an independent board member from the Humber Coast and Vale healthcare partnership (or ICS in the future).
5. The Hull York pathology service will act as an autonomous body providing pathology services for partner trusts without prejudice favour to either partner. That the new network is fully supported in the development of its own brand identity.

Essential Criteria		Assessed by	Recommendation
1	The financial impact of hosting will not disadvantage the host.	Finance Team: Financial Impact Assessment	The financial impact assessment and the agreed operating principles in the Finance case neither trust will be disadvantaged by the hosting arrangement. Both trusts will be contracted and treated as service users. Financial and strategic accountability will be through the oversight board. Work is on-going to understand the impact of IFRS 16 but it does not influence the recommendation for the host.
2	That the choice of host offers the best opportunity to deliver financial savings for the wider system.	Finance Team: Legal Advice	The legal assessment of this criteria is that both trusts will be able access the LLP services and this offers the opportunity for saving through VAT reclamation. The cost/benefits of accessing this service are the same regardless of the host.
3	The choice of host does not negatively impact on the ability of the new network to deliver its current and future service (as per TOM)	Steering Group	There are no strategic elements that would suggest either trust is better to host than the other in respect to hosting the new network and the TOM. The legal advisors have provided assurances
4	The prospective host and partner trust agree to put in appropriate contractual and governance processes in place as per the management case outlined below.	Steering Group	

			that the contractual arrangements for the new network will bind the trusts equally to supporting the new network.
5	That the host trust and partner trust recognises the autonomy of the new network	Steering Group	At this point there are no objections raised to the proposed oversight structure in the business case. The legal advisers for the programme provide assurances that appropriate binding contracts can be put in place to assure the autonomy of the new service and also appropriate accountability to the host, partner trust and ICS. Ultimately this decision is one for the respective trust boards.

Table 10: Hosting decision matrix

Recommendation 2b

There are no clear differentiating operational factors in the assessment of the steering group in considering the recommendation for a host organisation. The legal advice is clear that in terms of access to YTHFM LLP and the cost savings attached to that is simpler should the host the York Teaching Hospital Foundation Trust. Whilst similar levels of savings can be achieved via a contractual agreement between HUTH and YTHFT it would be necessary to give a clear rationale to the trust executive boards why the simpler option would not be selected. There are no strategic elements that would suggest either trust is better to host than the other; the steering group asked why would we not choose the most straightforward route? In that regard the steering group recommend the board's request YTHFT to act as the host organisation for the new pathology network. In making its recommendation the steering group would highlight to the trust boards that the underlying ethos of the new network is to develop a brand, an identity for the new Hull York Pathology Service.

MANAGEMENT CASE

Introduction

A team of people have been in place since the collaboration programme was initiated in September 2018. The programme team consists of representatives from partner trusts and pathology, finance, and planning subject matter experts. The team was coordinated by a programme director and clinical programme director. The work of the team was overseen by the Pathology Collaboration Board. In May 2019 the board terms of reference where changed to begin the process of developing the business case for the future pathology network based upon the outputs of the service review. It is proposed that the collaboration board will be replaced by a formal appointed management team that will manage the transition to the new organisational form and beyond the anticipated go live date.

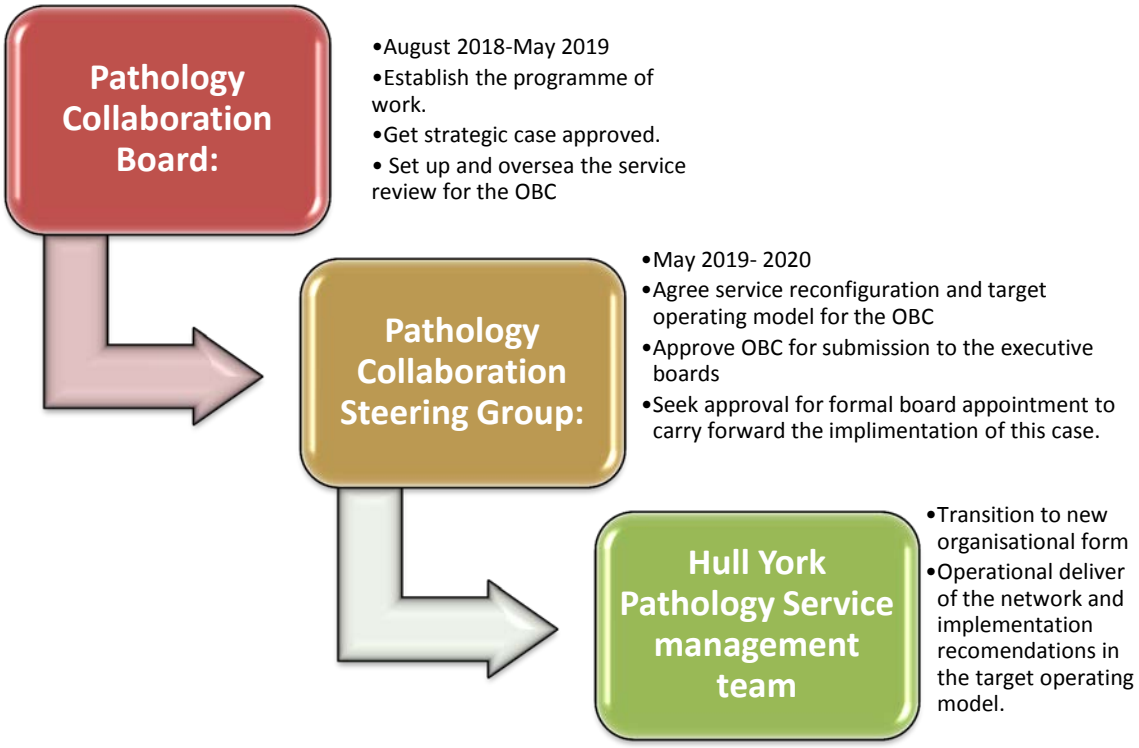

Figure 5: Programme management

The purpose of this section of the business is to outline the high level actions and governance arrangements that are needed to establish the proposed pathology network in the configuration described. The management case describes the control frameworks to be used to implement the recommendations in the business case including:

- Pathology Oversight Board.

- Proposed HYPS management structure.
- Programme management and governance for the transition to the new network including:
    - Clinical and corporate governance structures
    - Programme management arrangements and plans
    - Risk Management arrangements
    - Objective realisation management
    - Post project evaluation arrangements

Hull York Pathology Service management

The pathology collaboration steering group propose that the host trust set up a formally appointed network management team for the Hull York Pathology Service (HYPS).. This network will be led by the new management team and will be accountable to the respective partner trusts through an oversight committee. At present each pathology/laboratory service has a senior management team in place. These teams will need to merge to form the network management team, A contractually agreed management team is the next step for the planning, implementation and delivery of the network whilst maintaining effective operational services. The team will set up a senior laboratory management organisational structure for the transformation of the pathology laboratory services across HUTH and YTHFT and develop the long term plan for the service. They will provide assurances to the executive boards on the progress and effectiveness of the new network through a pathology oversight committee. The management structure includes the clinical and senior management teams from the Hull and York pathology services, and representation from corporate teams. This group will constitute the network board. Management Structure detailed in Appendix B.

The network board will be responsible for the delivery of the long term plan for pathology as laid out in the strategic case.

Operationally the new pathology network will serve all the trusts equally in providing high-quality pathology service and as such needs a distinct identity. Moreover, staff are more likely to be equally and significantly engaged (in a challenging transformation) if they can identify a common loyalty to a new ‘brand’. The management structure in Appendix B outline a bespoke innovative approach distinct from existing arrangements in individual trusts. An Operational Delivery Group will support the board in maintaining the current standard of service and the transition to the target operating model. To facilitate this transition a separate Network Delivery group including the Programme Management Office shall be created to develop the strategies outlined in this business case into deliverable plans and translate these plans into business as usual. The PMO is time limited with the remit to complete the transition and transformative changes by 2023. (see Programme of Activities)

The new pathology network will require a degree of operational flexibility to set and execute its own priorities and objectives to grow as a sustainable service and to meet clinical needs of the HCV partners; it is unlikely to have this as part of the trust “healthcare”/”care” group

system. The pathology network will be required to operate with a degree of autonomy and governance arrangements in accordance with the standing orders and scheme of delegation of the host trust. The newly formed service will follow the established governance processes and reporting laid out in Appendix A. Key to the governance process will be the creation of an oversight committee as part of the standing committees for the host trust. This oversight committee shall have equal representation of the partner trusts and will have an independent chair from the HCV Healthcare partnership.

Financial Impact of the Management proposal

The proposed changes to the management structure on consolidation are set out below

Current Structure	£	WTE
Medical	90,800	0.4
AfC 9		
AfC 8d		
AfC 8c	232,502	3.0
AfC 8b	499,176	8.0
AfC 8a		
AfC 7		
AfC 6		
AfC 5		
AfC 4	21,892	1.0
Total Current	**844,370**	**12.4**

New Structure	£	WTE
Medical	129,000	0.8
AfC 9		
AfC 8d	98,551	1.0
AfC 8c	245,956	3.0
AfC 8b	349,201	5.0
AfC 8a		
AfC 7		
AfC 6	81,624	2.0
AfC 5		
AfC 4	21,892	1.0
Operating expenses	-44,000	
Total New	**882,224**	**12.8**
Additional Cost	**37,854**	

Table 14: Management costs

Recommendation 3

It is the recommendation of the steering group that in order to deliver the substantial reconfiguration of services outlined in the economic case and recommended option a new pathology management board should be appointed. In order to deliver the scale of changes at pace it is recommended that the management structure outlined in Appendix B is adopted and that the director level appointments are made within 3 months of approval of the case. These appointments should be joint HUTH and YTHFT appointments with authority to lead the new network on behalf of both trusts. The network directors will be responsible for the appointment of the senior network management team within 6 months. Furthermore, it is the recommendation of the collaboration steering group that senior operational management

team should be TUPE or Contracted (as appropriate) to the new host as soon as practicable in order to ensure an effective, safe transfer of service delivery to the new network. It is recommended that oversight of the HYPS should be provided by a shared oversight committee with executive representatives from partner trusts and the HCV ICS.

Programme of Activities and Support

In order to deliver the transition to the new network the current programme team should be supplemented to ensure that the various projects are coordinated and delivered on time. Alongside the current team working on the programme, a programme manager and administration assistant will be required. The HCV healthcare partnership Diagnostic Board provides has established a PMO for the wide range of diagnostic projects. The PMO will support the range of HYPS interrelated projects and will report to the Network Delivery Group.

Workstream/Projects	Milestones	Scope
Procurements and Contracts	Service users and commercial supplier contracting moved to new host by go live 01/04/21 High value laboratory contracts tendered and awarded 2023	Map all contracts for novation Procurement plan to consolidate non pay laboratory expenditure Major analytical contract tenders
Transport	Complete Review of transport systems Dec 2021.	Assess full range of transport needs. Develop future plan
LIMS	Go live in phases April –July 2022 ICE Go live as a network Dec 2020	Implementation LIMS project Rollout primary care connectivity.
Digital	NECA Go Live Dec 2020 Review uptake and utilisation against benefits Mar 2022 NPIC Go Live 2022	Implement Digital Pathology plan in Cellular pathology
Organisation Development	Branding and Cultural survey April 2021	OD plan TUPE staff to the host. Develop and Implement a 10 year workforce plan Consultant contracting
IT connectivity	Cross network connectivity between HYPS and partner trusts April 2021	Establish non Laboratory IM+T

Finance and Commercial systems	Operational Finance system April 2021 New schedule of prices April 2022	Financial management plan, inc costings and pricing plan Capital planning Contract Novation SLA's TUPE Budget Setting CRES/CIP agreement
Data and Information	Shadow NHSI data sets Q3 return Feb 2021 1st NHSI data set as a network Q2 2021	Develop network metrics in line with NHSI Model hospital Establish network baseline data. Establish mechanism to deliver the routine Quarterly and Annual data sets. Develop key performance metrics for the network.
Harmonisation to TOM Coordinating activities with the Operational Deliver Group	ASL at CHH Dec 2021 ASL at SH April 2022	Alignment to service delivery reconfiguration strategy mapping pathway to new service delivery options. Translation into the TOM. Identify best practice and opportunities to improve the appropriateness of use, and demand on pathology across the HCV ICS Develop Point of Care plan to support future service configuration. Service ability to outreach into primary and social care UKAS changes to single organisation
Other network connections		Create wider pathology partnership across Humber and Yorkshire: Clinical Pathway cross over Clinical network engagement Explore additional partner potential

Table 11 Details on the individual projects within the overall Pathology Programme.

Programme Management and Governance

The Pathology Collaborative Programme was established to provide leadership and oversight to the collaborative working between the two pathology service providers. The HYPS Board will establish a Network Programme Group to take over from the collaborative programme team to develop detailed plans for the future service configuration and alongside the Operational Delivery Group will manage the transition from the current service configuration. Membership of the Network Programme Group will include clinical and managerial representatives from HYPS. The work will be facilitated and supported by the diagnostic programme team from the Humber Coast and Vale healthcare partnership. The programme group will be accountable to the HYPS Board and will be time limited as individual projects and plans are incorporated into normal business and under the control of the operational delivery group.

Network Programme Group membership	
Network Director of Operations	Programme Manager
Clinical Directors	Finance and Business Partner
Network Business Manager	OD and Communications Partner
Change Manager	Programme Administrator

Table 12: Network Programme Team

The programme members shall be responsible for providing reports and information to the board. During the development of the business case Speciality Reference groups (SRG) were established to explore the emerging options from the service review. The SRG's will be maintained during the transition to the target operating model to provide valuable insight and response to the proposals and also assist in the organisational development process.

Clinical and Corporate Governance (Appendix B.)

As outlined above the HYPS board shall be accountable to an Oversight Committee. In addition, clinical and operational governance reporting will be through the established respective trust systems i.e. patient safety boards. Executive Governance structures detailed in Appendix B. The HYPS Board will be operationally accountable to the host trust executive committee

Communication Strategy/Stakeholder Engagement (Appendix C)

The HYPS board and delivery groups will undertake a proactive approach to communication with staff, service users and stakeholders from the outset. Engagement with stakeholders will be through formal and informal processes. Appendix C: Outline Communication Plan.

Risk Management Strategy (Appendix D)

A RIDHA register will be developed for the programme. The register will be updated to reflect the specific risks relating to individual projects and the wider programme associated with implementation of the preferred option. Risk mitigation and management actions have been identified for each of the risks and responsibilities and timelines assigned for their implementation.

The high level risks to delivery of the programme are detailed in Appendix D:

Programme Plan (Summary)

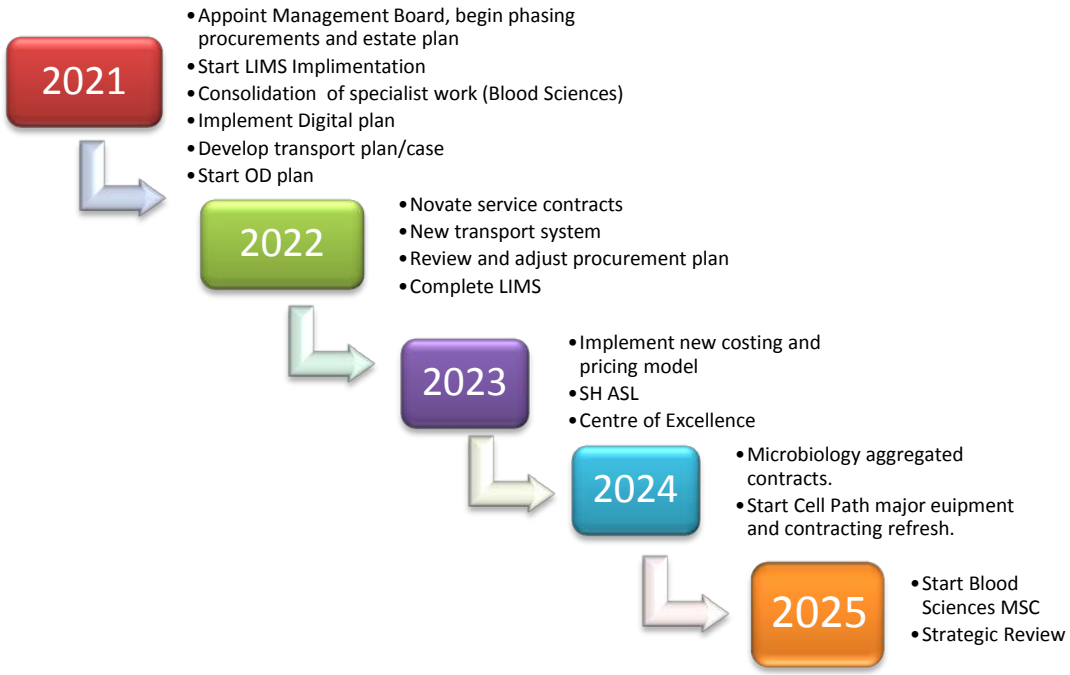

Figure 6: Summary of annual milestones. Detailed programme plan (Appendix E and G)

Benefits Realisation Planning (Appendix F)

The project plan for the implementation of the preferred option will include work-streams and tasks that enable optimum performance against the programme objectives. Detailed benefits realisation plan will be administered through the PMO.

Programme Evaluation

An evaluation will be carried out after each individual project has been completed and/or the programme has achieved a significant milestone, these are identified in the detailed programme plan. The evaluation process will include consultation with appropriate stakeholders on performance, timescales and the deliverables from each milestone.

Recommendation 4

It is the recommendation of the collaboration steering group that the schedule of programme be accepted and partner boards support the request to the HCV healthcare partnership for the support of the diagnostic programme team to assist in the transition process. The programme to run until 2023.

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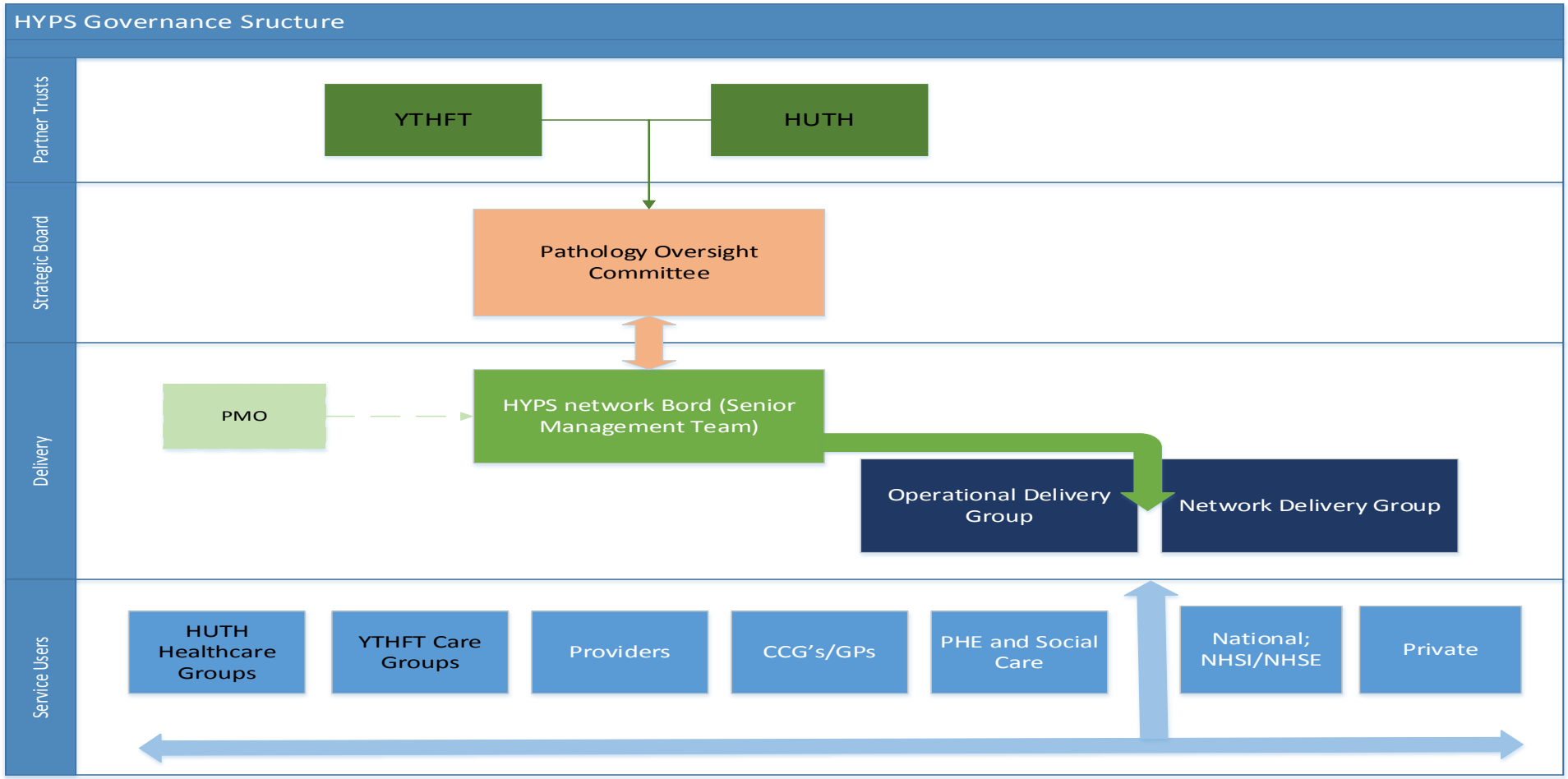
Appendix A: Management Structure.

Membership	Responsibilities
Oversight Committee:	
• Non Executive Chair (rotational) • Partner trust Non Executive representative • YTHFT COO • HUTH executive management representative • YTHFT executive medical representative • HUTH executive medical representative • HYPS Medical Director • HYPS Director of Operations • Primary Care Representative • HYPS Finance manager • HYPS HR partner	The partner trusts in the contractual joint venture are required to form an oversight body with board level executive representatives. The committee is a standing committee of the host trust with equal representative from the partner trust. It is a representative body of the respective trusts Board of Directors. The HYPS shall be represented at director level by appointed Director of Operations and Medical Director. The oversight committee provides assurance to the respective partner trusts about the operational effectiveness of the network. The oversight committee shall agree and sign off the strategic plan for the service including the setting of key milestones, sign off and approve annual operational plans. The committee will hold the HYPS Management Board to account for the safe, effective and efficient delivery of the pathology service.
Senior Management Team (Network board)	
• HYPS Medical Director • HYPS Director of Operations • Clinical Director for York and Scarborough • Clinical Directors for Hull • Head of Microbiology and Cellular Pathology • Head of Blood Sciences • HYPS General Manager • HYPS Finance Manager • HYPS HR Partner • Programme Manager	The management board would be directly accountable to the Board of Directors of both organisations for the performance of the Pathology service via the oversight committee. Accountable for the provision of value added, cost effective pathology services across multiple health sectors. Accountable for the safe and effective delivery of pathology services across the Hull/York/Scarborough region. Management board shall establish standing committees to ensure safe and effective operational delivery*: Clinical Governance, Finance and Performance, Business and Operations.* Holds the operational and network delivery group to account.

Operational Delivery Group: 2 x Business Teams:	
• Clinical Leads • Head of serve (M/CP or BS) • Business Manager • Laboratory Managers • Operational Managers • Quality manager • Training Manager	Accountable for the delivery of appropriate laboratory services, right test, right time and right place. Maintains patient focus. Maintain effective operational capacity and allocation of resources. Develop and Maintain an integrated Quality Management system across the network Deliver a service that value the staff and provides meaningful career pathways for all. The Operational delivery group via the service specific business teams will maintain open and effective dialogue with service users in line with standards of accreditation. The Operational delivery group will be responsible for the safe and equitable delivery of pathology services across all hospital sites, primary care CCG's and community care providers.
Network Delivery Group: Programme workstreams:	
• HYPS Director of Operations • HYPS General Manager • Change Manager • Programme Manager • LIMS/Digital Project Manager • Business and Planning representative • OD and Comms Representative • HR Partner • Finance Manager	Translate the approved business case into the target operating model for the network. Develop and Coordinate OD policy and plan for the network. Coordinate the network procurement plan Develop and submit proposals for development of Infrastructure projects ie Estates and Transport Translate business proposals, procurement plans and workforce plans to realise the network benefits. Develops and manages the risk and benefits relating to the developing network.
Programme Managemnt Office (PMO)	
• Programme Manager • Programme Administrator	Supports the network delivery group with the development and administration of the programme of work agreed by the HYPS board for the transformation of laboratory services in line with target operating model. Accountable for the delivery of the programme to the HYPS Management Board. Provide a link with the HC&V Strategic Diagnostic Board. Manage programme interdependencies and link with designated managers within the network and operational groups.

Appendix B: Governance



Appendix C: Outline Communications Plan

	Patient/public engagement	Pathology staff engagement	GP engagement	Clinical engagement	All staff (YTHFT, HUTH)	ICS/CCG
Service review and business case	N/A	High level	N/A	N/A	N/A	N/A
Approach	Reactive	Proactive	Reactive	Reactive	Reactive	Proactive
Method	Press statement	Staff emails from programme director	CCG email	Corporate communications	Corporate communications	Briefings
Workforce model and organisational development	N/A	Detailed/specific	N/A	N/A	High level	N/A
Approach	Reactive	Proactive	Reactive	Proactive	Proactive	Proactive
Method	Press statement	Co-ordinated and consistent staff briefings delivered by Exec lead	CCG email	Corporate communications	Corporate communications	Briefings
Reconfiguration Approach	N/A	Detailed/specific	Detailed/specific	Detailed/specific	High level	High Level
Approach	Reactive	Proactive	Proactive	Proactive	Proactive	Proactive
Method	Press statement	Co-ordinated marketing campaign	CCG email/safety alert/formal letter	Co-ordinated marketing campaign	Corporate communications	Briefings

Appendix D: Programme Risks

Risk	Impact	Likelihood	RAG	Mitigating Actions	Residual Risk
Inability to put the network together	Major	Unlikely	Medium	Engagement and executive board approval. NHSI approval	Low
Failure to Implement the preferred options	Moderate	Possible	Medium	Detailed plan and transition arrangements. Project teams in place for keystone projects such as LIMS, Digital and estates. Programme management office established to ensure effective programme control.	Low
Strategic Alignment: not meeting strategic fit	Moderate	Unlikely	Medium	Continual discussion with NHSI and HCV partner. Active participation of stakeholders.	Low
Does not meet savings potential	Major	Possible	High	Detailed plans for procurements and timelines for equipment and service changes. Establish project teams and boards to deliver key elements of the programme. Programme management office established to ensure effective programme control. Appoint procurement manager.	Low
Option not sustainable beyond 2024	Critical	Possible	V High	Monitor service performance against agreed benefits table. Agree key milestones and stop points to keep programme on track to meet guiding goals. Oversight committee and HCV CAG to inform changing strategic priorities.	Medium
Ability to access capital	Major	Likely	High	Follow up securing capital from various sources inc STP, NHSE/NHSI, private borrowing etc. Develop ‘ready to go’ plans for the developments identified in the econ	Medium

Appendix E: Programme Transition Plan

Transition			
Workstream	*Activity/Task*	*Sub task*	*Interdependencies*
Finance	Stocks and Balances	Equipment lists	Contracting and LIMS
		Stock Lists	
		IFRS Matching	
	NHSE/I Balance sheet		
	Estate charges		
	Corporate charges		
	LLP		
	CNST		
	Staffing	AfC Costs	
		Medical staffing costs	
		Salary Sacrifices	
	Trading	HG/CG accounts	
		Price alignment	
	Reporting	Monthly reports	
		Reconciliation	
		Unitary Charges	
	Contracting	Contract with HD for legal process	
		Service and supplier contract novation	
	SLA's	Listing internal service and trust-trust	
	Management changes	Mid managers and operational managers	Management case and costings
		Finance and business processes training for managers	
IT	LIMS Project	Project team in place	Finance
		ICE	
	Digital Project	Implement NECA	
		Transition to NPIC	

		Appoint project manager for NPIC	NPIC Project plan
		Agree buy out of assets	
	Non LIMS related	Email and network comms	
		Q-pulse	
		Ancillary systems, data sharing etc	
Organisation Development	Management structure	Agree whole structure	Management case and finance
		Job Descriptions and matched roles	
		Central services team inc QM, TM and IT teams	LIMS
	OD/Comms	Staff engagement events	Comms plan
		Branding	IT
Data and Performance metrics	National Returns	Q4 20/21 shadow aggregated network submissions	
		Develop shared BI reporting (monthly)	Finance
		Develop service KPI's	
		Combined PQAD	
Procurements	Full contractual alignment	Schedule of Procurements: Gap assessment	Finance plan
		Establish milestone tenders/etc	Business case plan
	Transport	Preliminary exploration of transport needs	Finance
Other	GP Optimisations mapping		
	Prep clinical alignment and harmonisation		LIMS
	Establish working communications with ICS partners		
	Agree/Contracting with other pathology networks		Finance

Appendix F: Benefit Table

Summary of programme Benefits

Benefit Area (refer to options appraisal)	Specific Benefit/Quantitative (Qn) or Qualitative (Ql)	Key Performance Indicator (Target value)	Baseline Measurement	Measurement/Source of Evidence	Benefit Owner (Monitoring/ Management Assurance)	Target Realisation Date(s)
Strategic Fit	Integrated pathology diagnostics across the HCV region and improved productivity.	Service demand optimisation	Model hospital data set 2018/19.	Laboratory IT and BI	PD	2021
Operational Benefit	Harmonised diagnostic service, reduced duplicate testing and removal of inappropriate tests.	PQAD and NHSI Model Hospital data	Model hospital data set 2018/19. PQAD 2019/20 Q4 Data set	Laboratory IT and BI Qn and QI based upon the basic data sets	PD	2023
Clinical Benefit	Flexible and appropriate diagnostic service provision consistent across the region. Ability to adopt and implement new diagnostics at scale.	PQAD and Clinical Audits	2019/20 Q4 data set. Laboratory Quality improvement system	Laboratory IT and BI. Qn and QI based upon the basic data set. Clinical Audit and feedback.	PMD	2023

Workforce	The size of the new organisation will offer more dynamic and diverse roles, across sites, in bigger teams, with broader and more challenging work placements. The variety of working environments, large lab through to ASL will support the development of new skills and provide staff with opportunities for different career pathways. There will be planned developments and opportunities to introduce and use expert and advance scientist roles to replace and/or underpin medical consultant posts.	HR KPIs'	Model hospital data set and divisional/directorate end of year reports	HR and BI		Ongoing - 2023

Appendix G: Programme Road Map

2021

- Appoint Management Board, begin phasing procurements and estate plan
- Transfer provider contracts.
- Start LIMS Implimentation
- Consolidation of specialist work in Immunology and Clinical Biochemistry
- Cell Path: Implement Digital plan: Begin NPIC project.
- Microbiology, reconcile sexual health testing to single site
- Complete changes to CHH QC laboratory
- Tender new Emergency Transport contract
- Begin Transport review
- Begin consolidated costing and pricing plan
- Start OD plan
- Novate SM contracts to LLP
- Consolidate primary optimisation process across whole region

2022

- Complete LIMS Installation
- Tender/Contract new transport system
- Develop "Grow our Own" staff training policy
- Cell Path: Recruit and begin developing advanced practitioners
- Cell Path: skill mix adjustments.
- Microbiology: adjust workforce plan post COVID.
- Complete move microbiology staff moves to YH.
- Reconcile virology and molecular testing to single site
- Begin phased approach to form ASL at Scarborough
- Blood Sciences: Multiskilling staff at Scarborough.
- Next phase of the primary care optimisation plan using LIMS/ICE functionality

2023

- Impliment new costing and pricing model
- Microbiology: begin aggregating supplier contracts to single managed service contract.
- Blood Sciences: small contract tenders.
- Blood Sciences: complete consolidation of specialist testing to single site.
- Arrange bridging contract for HUTH Clinical Biochemistry
- Set up training and development Network "Centre of Excellence for Pathology"

2024

- Tender for Pan-Microbiology contracts (1.2m)
- Blood Sciences begin 2 year tender process for combined biochemistry contracting
- Begin program to aggregate MSC's

2025

- Cell Path: Equipment refresh and rationalisation across sites
- Strategic Refresh

2026

- Complete Biochemistry tender (3.4m)
- Cell Path: Anticipated Consultant level BMS staff in post

2027

- Haematology tender (2.8m)

2028

- Full Service contracting options. Completion of aggregated MSC's

Appendix H: Embedded information

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Hosting criteria

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Hull University Teaching Hospitals NHS Trust

Workforce, Education and Culture Committee

17 December 2020

Title:	Quarterly Report on Safe Working Hours: Junior Doctors in Training - for quarter: 1 July – 30 September 2020
Responsible Director:	Professor Mahmoud Loubani – Guardian of Safe Working Hours
Author:	Professor Mahmoud Loubani – Guardian of Safe Working Hours

Purpose:	The purpose of this report is to inform the Workforce, Education and Culture Committee of the current position in relation to: • Guardian of Safe Working Hours appointment • Junior doctor working hours • Exception reports, where appropriate • Rota gaps • Locum usage • System-wide junior doctor issues, where appropriate	
BAF Risk:	BAF Risk 2 - Staffing	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	
Summary Key of Issues:	There were 2 fines that have been issued within this quarter. To be able to ensure safe working hours are maintained, it is important that all departments are using E-rostering system.	

Recommendation:	The Workforce, Education and Culture Committee meeting is requested to receive this report and: • Decide if this report provides sufficient information and assurance • Decide if any further information and/or actions are required

Quarterly Report on Safe Working Hours
Doctors and Dentists in Training
1 July – 30 September 2020

Executive Summary

The Guardian Report for this Workforce, Education and Culture Committee meeting covers the quarter from July 2020 to September 2020.

Exception Reporting patterns and responses

There were a total of 127 exception reports with a total of 127 episodes reported by trainees. The most common reason for submitting an exception report still appears to be related to volume of work which leads to trainees staying beyond the contracted hours. Other reasons include missed educational and training opportunities as well as staying beyond contracted hours in the interest of patient care and staff shortage.

In this quarter the following number of episodes of exceptions reported per Health Group

Clinical Support - 3
Family and Women – 1
Medicine – 55
Emergency Medicine - 2
Surgery - 65
GP placement – 1

Exception Report trends:
Anaesthetics: This was the area with the most exception reports (29 episodes) in this quarter. One trainee submitted 29 reports on one day for exceptions that occurred between October and June 2020 and these reports were closed in July. The main reasons for these reports relate to missed breaks and the completion of portfolio work in the trainees own time.

Summary

A lot of long outstanding reports from have now been completed within this quarter. During the first wave of COVID, many reports were completed by the Guardian of Safe working on behalf of the supervisor. There is a process in place to chase the supervisors for the completion of these reports and this process has now been re-instated for this quarter.

Issues:

All departments to use eroster to allow safe working hours to be monitored and to ensure the departments are adhering to the Junior Doctors Terms and Conditions.

The lack of support from Phlebotomy continues to be highlighted as an issue via exception reporting and from feedback raised at the Junior Doctors Forum.

Questions for consideration

The Workforce, Education and Culture and committee meeting is requested to receive this report and:

- Decide if this report provides sufficient information and assurance
- Decide if any further information and/or actions are required

Professor Mahmoud Loubani
Consultant Cardiothoracic Surgeon
Guardian of Safe Working Hours
Encl:
Appendix 1: Board Report GSW 1 July 2020 – 30 September 2020

Appendix 1

Hull University Teaching Hospitals NHS Trust

Quarterly Report on Safe Working Hours
Doctors and Dentists in Training
1 July – 30 September 2020

1. Purpose of this Report

Under the 2016 Terms and Conditions of Service, the Guardian of Safe Working Hours must report to the Board at least once per quarter. This report sets out data from January to March 2020 with reference to:

- Exception reports and monitoring
- Locum usage, both bank and agency
- Vacancy levels amongst trainees
- Work schedule reviews and fines

2. High Level Data

Number of doctors / dentists in training (total): (establishment)	562
Number of doctors / dentists in training on 2016 TCS (total FTE's):	532.6
Amount of time available in job plan for guardian to do the role:	1 PA / 4 hours per week
Admin support provided to the guardian (if any):	1 WTE
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee (max; varies between HGs)

All trainees in the Trust are now on the 2016 terms and conditions of service (TCS) and have received their work schedules. An electronic exception reporting system is running well and all trainees and trainers have been given access and offered training on the system.

Trainees on the 2016 TCS are issued with a **work schedule**, which sets out the working pattern, rota template and pay, and also sets out the training which they can expect to receive during the placement. Health Education England has agreed a Code of Practice regarding the timescales by which trainees should receive this information.

Trainees submit an **exception report** if their work varies significantly and/or regularly from that set out in the work schedule. They can also submit an exception report if they do not get the expected training (e.g. they miss a scheduled clinic due to providing ward cover for an absent doctor).

Exception reports fall into the following four categories:

- Difference in educational opportunities or available support
- Difference in access to training due to service commitments
- Difference in the hours of work
- Difference in the pattern of work (including failure to achieve natural breaks)

Exception reports are discussed by the trainee and their educational or clinical supervisor and an outcome is agreed. This may be overtime payment or time off in lieu (for extra working hours). For educational differences or where regular hour's adjustments are

required, a work schedule review may be appropriate. Alternatively, both parties may agree that no action is required and the report is filed for data collection purposes.

Educational exceptions are copied to the Director of Medical Education for action if needed. Hours exceptions are copied to the Guardian of Safe Working Hours, who reviews the reports, ensures (if the data is available) that trainees are working safely, and has the power to issue fines to departments if trainees are breaching their safe working conditions.
The Guardian of Safe Working ensures that the Health Groups are kept updated about problems identified in their areas so that appropriate action can be taken by the departments to maintain patient and junior doctor safety.

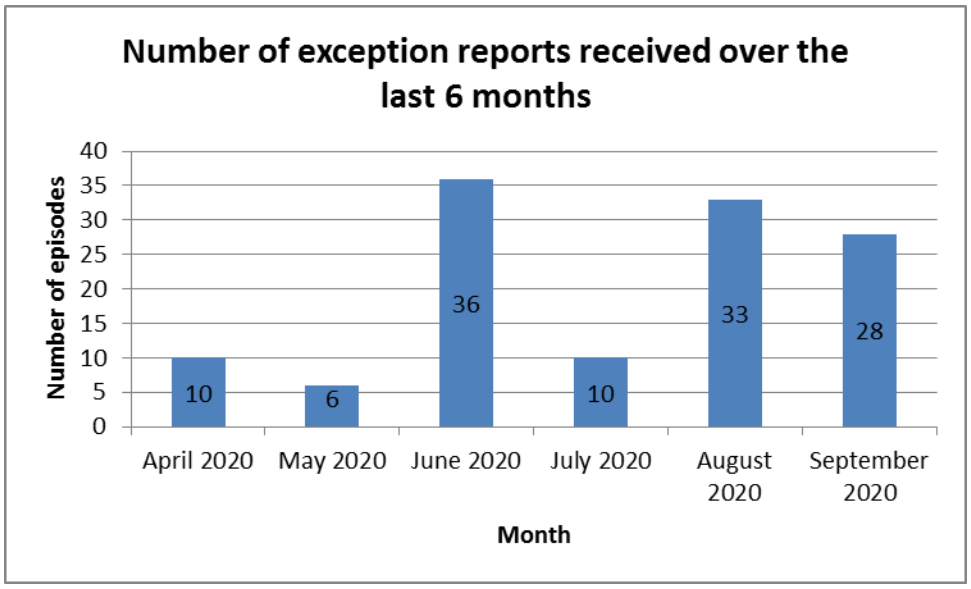
The Guardian of Safe Working Hours is also responsible for producing this quarterly report to the Trust Board. The data for the report comes from the exception reports, and from systems held or created by the Trust, particularly Human Resources and payroll data.

3. **Junior Doctor Working Hours**

The data in this section are presented according to a standard template which was produced by NHS Employers. At the request of HEE Yorkshire & the Humber, data will continue to be presented in this way to allow comparison to be made between Trusts across the region.
In all cases the data below is presented in relation to exception report episodes, since a single exception report may contain a number of episodes of concern.

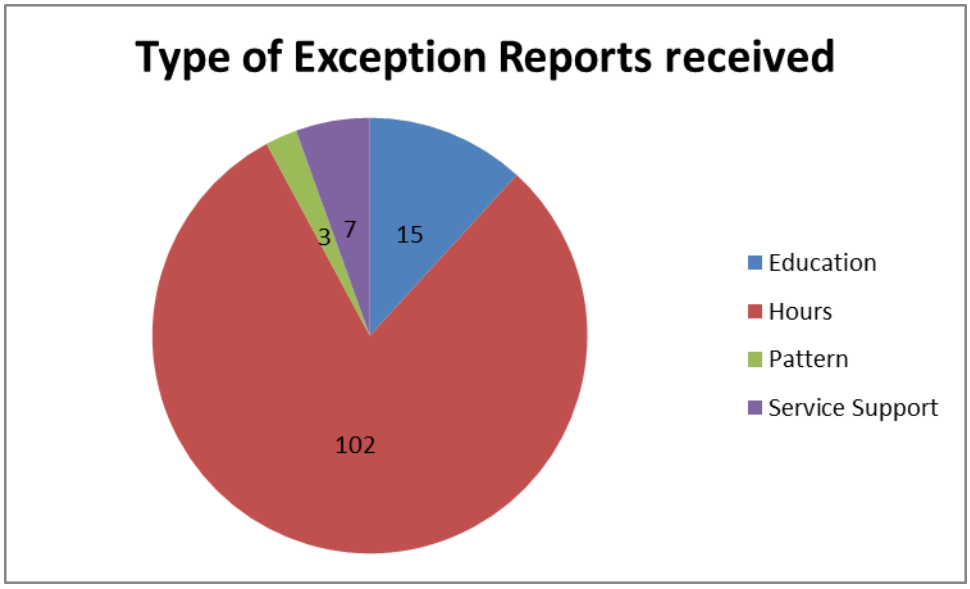
There were 82 exception report episodes submitted between 1 July and 30 September 2020 and 45 carried forwards from the previous quarter.

Exception reports over time



During the first wave of COVID, the number of exception reports dropped significantly. There was an increase in July due to one trainee submitting 29 reports on one day which were due to exceptions that had occurred from October 2019 up until June 2020. There are on average approximately 45 exception reports received within a normal month. The graph above shows that exception reports are starting to increase again.

Types of exception reports received 1 July – 30 September 2020



The main type of exceptions reported continue to relate to the difference in hours. The main reasons for working over include increased workload, staff shortages and patient care. Time back and payment can be paid for the difference in hours if this outcome is agreed with the supervisor.

Exception reports (episodes) by specialty 1 July – 30 September 2020

Specialty (Where exception occurred)	No. exceptions carried over from last report	No. exceptions raised (episodes)	No. exceptions closed (episodes)	No.exceptions outstanding (episodes)
5, 50, 500 COVID	4		4	
A&E		1	1	
Anaesthetics	28	1	27	2
Breast Surgery		3	3	
Cardiology		2	2	
Chest Medicine		4	4	
Colorectal Surgery	3		3	
Critical Care		1	1	
Elderly Medicine		18	18	
Emergency Medicine	1	1	2	
Endocrinology		15	15	
Gastroenterolgy		7	2	5
General Practice		1	1	
Major Trauma Centre		1		1
Neonates	1		1	

Neurology		8	4	4
Oncology		3	3	
Orthopaedics		1	1	
Plastic Surgery	1	1	2	
Respiratory Medicine	2		2	
Trauma & Orthopaedics		8	4	4
Upper GI	3	5	8	
Vascular Surgery	2	1	2	1

Exception reports (episodes) by grade 1 July – 30 September 2020

Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
CT1	28	6	31	3
CT2		5	3	2
FiY1	2	2	4	
FY1	12	33	45	
FY2		20	12	8
GPST 1		5	5	
GPST R2		4	4	
IM2 ACCS		3		3
ST2	1		1	
ST3		1	1	
ST5	1	2	3	
ST6	1		1	
ST7		1	1	

F1 doctors are the most likely to report problems, particularly regarding working hours. They have been on the contract longer than any other group of doctors and are most familiar with the exception reporting mechanism; indeed, none of them have ever worked under any other contract. Foundation 1 doctors are the most junior of the trainees, and are learning how to work, how to manage their time, and, in many cases in this early part of the year, are learning how to do things for the first time. They are ward-based, and often feel that they cannot leave until all the jobs are done. As a group, they report reluctance to hand over routine daytime jobs to colleagues covering later in the day. The importance of appropriate and safe handover, and how to do this practically, forms part of the discussions with educational supervisors.

We are seeing a gradual increase in exception reports from other grades; however, numbers are much lower in comparison to Foundation doctors.

Exception reports (episodes) by rota 1 July – 30 September 2020

Rota	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
(2016) Rota 40 - Plastic Surgery SpR	1	1	2	0
2019 23 - Vascular Surgery F1 (inc. ENT/Uro)	1	0	1	0
2019 Rota 121 - Cardiology / Ct Surgery SHO	0	1	1	0
2019 Rota 124a - General Surgery (acute)	1	0	1	0
2019 Rota 134 - Orthopaedic/Orthogeriatric F2	0	3	3	0
2019 Rota 134 - Orthopaedics F2	0	1	1	0
2019 Rota 135 - Orthopaedic & Plastic Surgery C	0	3	3	0
2019 Rota 18 - Medicine F1	1	2	3	0
2019 Rota 18B - Medicine F1	0	12	12	0
2019 Rota 23 - Vascular HRI	1	0	1	0
2019 Rota 25 - Acute/Elective F1	5	7	12	0
2019 Rota 4 - Medicine F1	0	2	2	0
2019 Rota 73 - Anaesthetics SHO (Acute)	9	0	9	0
2019 Rota 76 - Critical Care F2 (Full Rota)	0	3	3	0
2019 Rota 8 - Oncology & Haematology	0	2	2	0
2019 Rota 83 - Anaesthetics (HICU2)	19	0	18	1
2020 Rota 14 - Medicine SHO blp 431	0	13	13	0
2020 Rota 15 - Medicine SHO (blp 450)	0	5	5	0
2020 Rota 2C - A&E SHO (PEM)	0	1	1	0
2020 Rota 5 - Medcine SHO (blp 215)	0	4	4	0
Rota 1 - A&E F2	0	1	1	0
Rota 121 - Cardiology / Ct Surgery SHO	0	2	2	0

Rota 135 - Orthopaedic & Plastic Surgery CT	0	2	2	0
Rota 14 - Medicine SHO blp 431	0	1	1	0
Rota 2 - A&E SpR (8 Man)	1	0	1	0
Rota 2 (Wards 5, 50 and 500) - 14 dr	5	4	9	0
Rota 25 - Acute/Elective F1	0	1	1	0
Rota 4 (Wards 80, 9 and 90) - 16 dr	0	6	6	0
Rota 5 (Wards 100, 11, 110) - 16 dr	0	3	3	0
Rota 56 - Neonates SHO	1	0	1	0
Rota 6 - RMO 1, 3 & 4	0	1	1	0
Sutton Manor GP Surgery F2	0	1	1	0

Exception reports (episodes) - response time 1 July – 30 September 2020

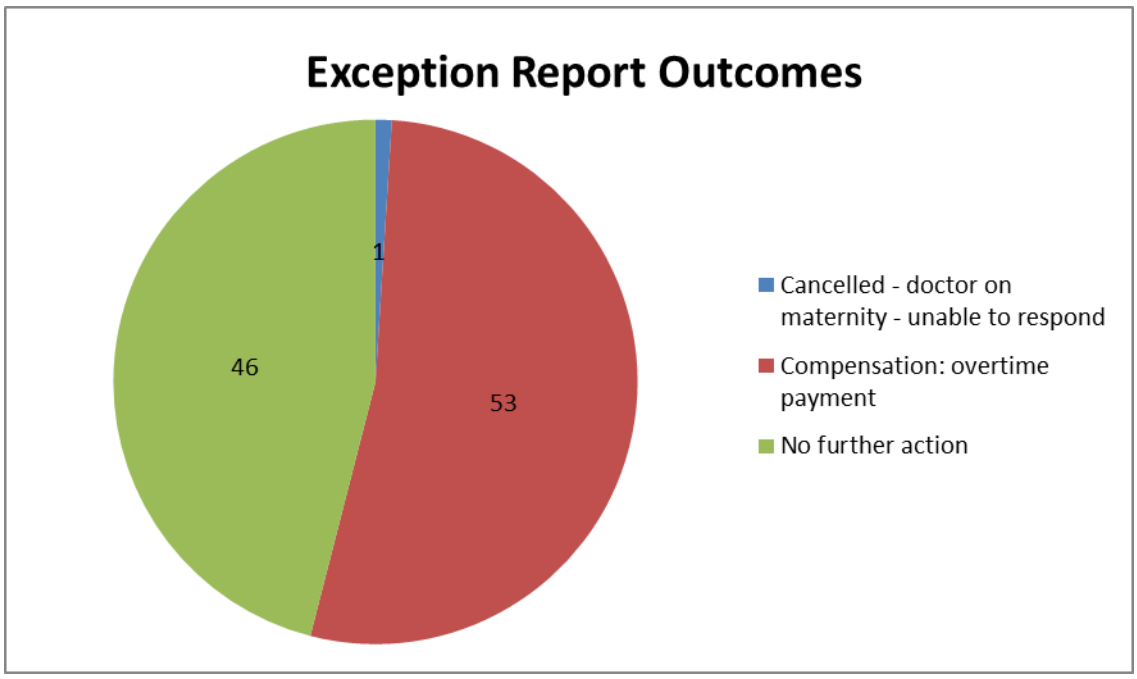
The 2016 TCS require that the trainer meets with the trainees to discuss an exception report within SEVEN days. This is a very difficult timescale to achieve, because of trainers and trainees often working on different shift patterns, but the timescale is there to ensure that safety concerns, including excessive working time, are addressed quickly.

Looking at response time by grade is not a particularly useful measure, but it is one that is requested by NHS employers. Of more use is response time by department, as this shows the areas either where trainers are not engaging in the exception reporting process, or where trainers and trainees are too busy to sit down and discuss or record the incidents.`

This is shown in the table below:

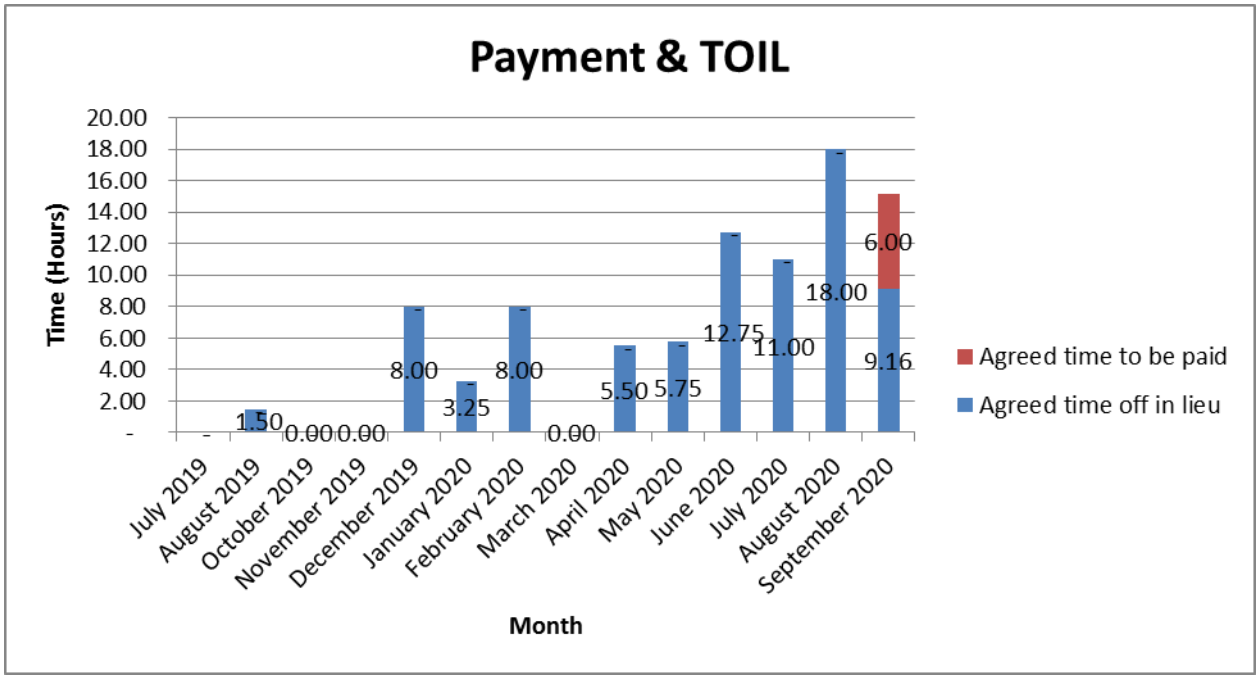
Grade	Addressed within 48hrs	Addressed within 7 days	Addressed in longer than 7 days	Still open
FiY1	2		2	
FY1	10	6	27	1
FY2	3		7	11
CT1		1	31	2
CT2	1		2	2
GPST1	1	4		
ST2			1	
ST3	1			
ST5			3	
ST6			1	
ST7			1	
IM2 ACCS				3
GPSTR 2			4	

Outcomes of completed exception reports 1 July – 30 September 2020



The above chart shows the outcomes of completed exception reports within this quarter. Compensation: overtime payment has been the agreed outcome for 48% of all completed exception reports. The decision whether to pay or give time back (or to take no action) is a joint decision between the trainee and the educational supervisor.

Payment and TOIL trends by month



Fines
We are now in a position to investigate any exceptions that lead to fines. The JD contract states, fines should be issued for the following breaches:

- A breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule);
- A breach of the maximum 13 hour shift
- A breach of the maximum of 72 hours worked across any consecutive 168 hour period.
- Where 11 hours rest within a 24 hour period has not been achieved (excluding on-call shifts);
- Where five hours of continuous rest between 22:00 and 07:00 during a non-resident on-call shift has not been achieved;
- Where 8 hours of total rest per 24 hour non-resident on-call shift has not been achieved

When an exception report has been submitted for the difference in hours of work, eroster is updated to reflect the actual hours worked. Eroster then highlights any breaches.

Fines will be issued at four times the basic / enhanced rate of pay applicable at the time of the breach. The doctors will be paid 1.5 times the rate and the remaining amount will be paid to the Guardian of Safe Working who uses the fines to support Junior Doctor Initiatives through the Junior Doctors Forum.

Where a concern is raised that breaks have been missed on at least 25% of occasions across a four week reference period, and the concern is validated and shown to be correct, the Guardian of Safe Working hours will levy a fine at the rate of twice the relevant hourly rate for the time in which the break was not taken.

Summary of fines this quarter.
The following 2 breaches have incurred a financial penalty:

CT2 trainee worked over by 30 minutes to help with on call duties. This led to a breach to 13 hour shift and minimum 11 hours rest rules on both occasions.

Multiple fines are issued for multiple breaches.

Work schedule reviews
There are currently no ongoing work schedule reviews as a result of exception reports by trainees. However, as part of the agreement of NHS Employers and the BMA on changes to the 2016 Terms and Conditions of Service, Medical Staffing will be reviewing all rotas within the Trust in line with the agreed working hours limits and working with the Health Groups and Doctors in Training to change rota patterns to be compliant with the updated T&Cs as required. So far, Medical Staffing have reviewed and updated (where required) 40 of the 67 rotas across the Trust as per the timeline agreed between NHS Employers and the BMA. This has been put on hold since March 2020 to support the Trust's response on the first COVID-19 wave.

a) Locum bookings 1 July – 30 September 2020

i) Bank 1 July – 30 September 2020

The Trust currently had an informal medical bank in place which strives to fill as many shifts internally as it can. This data does not include additional shift worked by rotational doctors. From 21st October 2019, the Trust has launched its 'Remarkable Bank' in a view to expanding it's use of internal Locums. We currently have 98 Medical Staff signed up to the 'Remarkable Bank' and we have also published an advert on the Trust's Website, NHS Jobs and the BMJ to attract external candidates onto the Bank. With the 'Remarkable Bank' going live, we are hoping to see an increase in Bank Locum Bookings and a decrease in the reliance of Locum Agency Staff.
The information in this table only covers shifts that have been booked by the Medical Staffing Team. There are a number of departments in the Trust that manage their own rotas and book their own bank cover for staffing gaps.

Locum Bookings (bank) by Grade				
Grade	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
F1	85	-	487.55	0.00
F2	343	28	2,378.59	174.00
FY3	4	-	39.00	0.00
CT/GPST R/ST1-2	522	75	2,970.70	606.00
ST3+	632	50	5,141.08	490.92
Total	**1,586**	**153**	**11,016.92**	**1,270.92**

**due to F1 doctors only possessing Provisional Registration with the GMC we cannot employ F1 doctors on bank contract*

Locum Bookings (Bank) by department				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Acute Medicine	371	20	2,824.47	220.17
Acute Surgery	194	-	1,392.27	0.00
Anaesthetics	20	19	142.25	139.25
Cardiology	25	4	206.35	37.50
Chest Medicine	7	-	61.00	0.00
Clinical Haematology	23	-	184.00	0.00
Clinical Oncology	33	-	0.00	0.00
Colorectal	52	-	514.25	0.00
Cremation Fees	3	3	3.00	3.00

CT Surgery	28	-	206.25	0.00
DME	9	-	67.00	0.00
ED Majors	1	-	6.00	0.00
Elderly Medicine	9	-	59.50	0.00
Endocrinology	5	-	52.00	0.00
ENT	43	-	79.50	0.00
Gastroenterology	15	3	117.00	39.50
Gynaecology	9	-	0.00	0.00
Haematology	3	-	0.00	0.00
Infectious Diseases	49	-	117.50	0.00
Medical Oncology	33	-	0.00	0.00
Medicine	1	-	9.50	0.00
Neonatology	5	-	37.50	0.00
Neurology	88	3	639.50	20.00
Neurosurgery	55	2	569.00	25.00
OMFS	6	-	102.00	0.00
Orthopaedics	115	16	796.00	71.50
Paediatric Surgery	53	1	374.50	4.00
Paediatrics	142	13	967.33	110.50
Plastic Surgery	5	-	45.00	0.00
Radiology	3	-	0.00	0.00
Renal	8	-	45.00	0.00
Renal Medicine	5	-	36.75	0.00
Rheumatology	73	68	622.50	578.00
Stroke	22	-	161.00	0.00
Trauma & Orthopaedics	31	-	243.00	0.00
Upper GI	17	-	142.50	0.00

Urology	2	1	37.50	22.50
Vascular	19	-	124.50	0.00
Vascular Surgery	4	-	31.50	0.00
Total	1,586	153	11,016.92	1,270.92

Locum Bookings (Bank) by Reason				
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Annual Leave	42	-	402.50	0.00
Covid-19 pressures	42	19	323.25	139.25
Covid-19 sickness cover	48	1	410.00	22.50
Extra Cover	62	24	359.65	205.00
Maternity/Paternity Leave	1	-	5.00	0.00
Other Leave	1	1	13.50	13.50
Sickness	46	4	347.00	33.50
Study Leave	1	-	8.00	0.00
vacancy	1,340	104	9,148.02	857.17
Total	**1,583**	**153**	**11,016.92**	**1,270.92**

ii) Agency 1 July – 30 September

Locum Bookings (Agency) by Grade				
Grade	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
F1	85	-	487.55	0.00
F2	343	254	2,378.59	1,834.44
FY3	4	-	39.00	0.00
CT/GPSTR/ST1-2	522	138	2,970.70	1,081.00
ST3+	632	258	5,141.08	1,909.16
Total	**1,586**	**650**	**11,016.92**	**4,824.60**

Locum Bookings (Agency) by department				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Acute Medicine	371	100	2,824.47	717.50
Acute Surgery	194	190	1,392.27	1,364.27
Anaesthetics	20	-	142.25	0.00
Cardiology	25	4	206.35	24.00
Chest Medicine	7	-	61.00	0.00
Clinical Haematology	23	23	184.00	184.00
Clinical Oncology	33	-	0.00	0.00
Colorectal	52	20	514.25	180.00
Cremation Fees	3	-	3.00	0.00
CT Surgery	28	-	206.25	0.00
DME	9	-	67.00	0.00
ED Majors	1	-	6.00	0.00
Elderly Medicine	9	-	59.50	0.00
Endocrinology	5	-	52.00	0.00
ENT	43	12	79.50	79.50
Gastroenterology	15	8	117.00	48.00
Gynaecology	9	-	0.00	0.00
Haematology	3	-	0.00	0.00
Infectious Diseases	49	-	117.50	0.00
Medical Oncology	33	-	0.00	0.00
Medicine	1	-	9.50	0.00
Neonatology	5	5	37.50	37.50
Neurology	88	6	639.50	38.00
Neurosurgery	55	16	569.00	139.50
OMFS			102.00	0.00

	6	-		
Orthopaedics	115	99	796.00	724.50
Paediatric Surgery	53	39	374.50	339.50
Paediatrics	142	121	967.33	856.83
Plastic Surgery	5	3	45.00	45.00
Radiology	3	-	0.00	0.00
Renal	8	-	45.00	0.00
Renal Medicine	5	-	36.75	0.00
Rheumatology	73	2	622.50	23.50
Stroke	22	-	161.00	0.00
Trauma & Orthopaedics	31	-	243.00	0.00
Upper GI	17	-	142.50	0.00
Urology	2	-	37.50	0.00
Vascular	19	-	124.50	0.00
Vascular Surgery	4	2	31.50	23.00
Total	1,586	650	11,016.92	4,824.60

Locum Bookings (Agency) by Reason				
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Annual Leave	42	17	402.50	138.50
Covid-19 pressures	42	23	323.25	184.00
Covid-19 sickness cover	48	47	410.00	387.50
Extra Cover	62	-	359.65	0.00
Maternity/Paternity Leave	1	-	5.00	0.00
Other Leave	1	-	13.50	0.00
Sickness	46	3	347.00	45.00
Study Leave	1	-	8.00	0.00
vacancy			9,148.02	4,069.60

	1,340	560		
Total	**1,583**	**650**	**11,016.92**	**4,824.60**

Please be aware that the above figures for Agency use show a high number of shifts booked due to a number of departments booking long term Agency staff to ensure that rota gaps are covered consistently. The Trust's difficulty in recruiting to certain departments within the Trust has required that they have to rely heavily on the use of long term bookings to ensure that rota gaps are covered.

As the Trust's systems for data capture improve, both the available bank and agency information raise more questions, such as: What is the effect on departments if identified gaps are not able to be filled by bank or agency locums? It is also clear that more detailed information is required to identify the reasons behind the need for locum cover; for example sickness is not mentioned as a reason for seeking cover. This has probably been included in the catch-all term 'vacancy' but will need to be teased out in future.

iii) Emergency Department
The Emergency Department books its own doctors directly; these figures are currently reported slightly differently.

Locum Bookings by 01.7.20-30.9.20 AGENCY					
Specialty	Number of shifts requested	Number of shifts Worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Emergency Medicine	430	282	430	3870.91	2563.91

Locum Bookings by 1.7.20-30.9.20 INTERNAL					
Specialty	Number of shifts requested	Number of shifts Worked	Number of shifts given to internals	Number of hours requested	Number of hours worked
Emergency Medicine	824	367	824	3164.61	2906.11

b) Locum work carried out by trainees 1 July – 30 September 2020
This data is collected to help assess whether individual trainees are in breach of the WTR and the 2016 TCS, or at significant risk of breaching. HEE are particularly interested in the results in this section, but, as yet, the information is not fully available using the current systems. Further information is required about the trainee's rostered hours and the actual hours worked.

At present the data is collected in an aggregated form by department, rather than on a trainee by trainee basis. The table below represents the top 10 doctors that have worked the most extra hours and whether they have opted out of the EWTD.

Base Specialty	Grade	Number of hours worked	Number of hours rostered per week	Opted out of EWTD
Endocrinology	ST3	134	40	Yes
Neurosurgery	ST3	104	40	Yes
Acute Medicine	ST3	96.5	40	No
Neurosurgery	ST3	94	40	No
Acute Medicine	ST3	62.5	40	No
Acute Medicine	CT1	61	40	Yes
Acute Medicine	ST3	53	40	No
Acute Medicine	ST3	50	40	Yes
Neurosurgery	ST3	50	40	No
Acute Medicine	CT1	47.5	40	No

Please be aware that the above extra hours may not necessarily have been worked in the base speciality mentioned. Especially at F2 level, doctors are able to pick up shifts at their level across Health Groups due to the rotational nature of their posts with the Trust.

The rostered hours on all rotas are known to be within safe limits, but live, real-time information is required on, for example, late working, swapped shifts, and extra shifts worked for locum pay. E-roster is capable of recording this information, but this requires working patterns to be updated live and rotas to be locked down for analysis. The appointment of rota co-ordinators is in progress across the Trust as part of the roll-out of e-roster for medical staff, and entry of this data will be a key part of their role.

Trainee opt-out from the Working Time Regulations is collected systematically from new starters is recorded on ESR so that this information can be used live when trainees book shifts.

Historically, trainees at risk of breaching the Working Time Regulations by doing lots of extra shifts, even with an individual opt-out, have not been easy to police. The Medical Staffing team utilise e-Roster for the rotas covered by their team. The system has EWTD and 2016 T&Cs rota rules built in and it is clear to the team when a doctor offering extra hours will be at risk of breaking any of these rules. A doctor will not be allowed to book themselves in for extra hours if this risks breaking any of these rules however Medical Staffing are not responsible for overseeing booking extra hours for all rotas. In order for all departments to ensure that they are not booking doctors for extra hours against these rota rules, the full utilisation of e-Rostering for junior doctors' rotas is required

Hull University Teaching Hospitals NHS Trust - Junior Doctor Rota Establishment Effective 30.9.2020

	Trainee Establishment						Rota Establishment						In Post							
Department	F1	F2	CT/ST1-2	GPSTR	ST	Total	F1	F2	CT/ST1-2	GPSTR	ST	Total	F1	F2	CT/ST1-2	GPSTR	ST	Total	% Posts filled 30/6/20	% Posts Filled 30/6/20
Academic, GP, Psych, Community	5	31	0	50	0	86	5	29	0	77	0	111	4	31.6	4.29	68.4	0	108.29	69.50%	97.56%
Acute Medicine	3	6	9	0	6	24	3	6	9	0	7	25	3	4	9	0	6.8	22.8	116.67%	91.20%
Anaesthetics	4	4	15	0	28	51	4	4	16	0	40	64	3	2	19.85	0	37.74	62.59	89.29%	97.80%
Breast Surgery	2	0	1	0	2	5	2	0	1	0	4	7	1	0	1	0	4	6	100.00%	85.71%
Cardiology	2	1	4	1	9	17	2	1	4	1	12	20	2	1	3	0	13	19	85.00%	95.00%
Cardiothroacic Surgery	0	3	0	0	3	6	0	3	0	0	9	12	0	4	1	0	6	11	83.33%	91.67%
Chemical Pathology	0	0	0	0	2	2	0	0	0	0	2	2	0	0	0	0	0	0	0.00%	0.00%
Dermatology	1	0	0	1	0	2	1	0	0	1	0	2	1	0	1	0	0	2	100.00%	100.00%
Elderly Medicine	5	3	6	7	6	27	5	3	6	7	7	28	5	3	6	7	7	28	116.67%	100.00%
Emergency Medicine	0	12	6	6	8	32	0	12	6	6	8	32	0	11	8.51	0	32.6	52.11	115.63%	162.84%
Endocrinology	3	0	2	0	4	9	3	0	2	0	4	9	3.6	0	2	0	3	8.6	122.22%	95.56%
ENT	1	1	2	1	4	9	1	1	4	1	6	13	0.67	1	4	0	6	11.67	84.62%	89.77%
Gastroenterology	3	0	2	0	5	10	3	0	2	0	5	10	3	0	0	0	7	10	110.00%	100.00%
General Surgery	14	1	5	0	7	27	14	1	6	0	18	39	9	1	2	0	8.71	20.71	71.79%	53.10%
Haematology	1	0	2	0	4	7	1	0	2	0	7	10	1	0	2	0	4.68	7.68	120.00%	76.80%
Histopathology	0	0	0	0	4	4	0	0	0	0	4	4	0	0	0	0	4	4	25.00%	100.00%
Infectious Diseases	2	0	2	0	5	9	2	0	2	0	5	9	4	0	1	0	6	11	133.33%	122.22%
Neurology	2	2	4	0	5	13	2	2	4	0	6	14	2	3	2	0	4.8	11.8	100.00%	84.29%
Neurosurgery	1	1	2	0	4	8	1	1	6	0	11	19	1.6	0	2	0	13	16.6	89.47%	87.37%
Obstetrics & Gynaecology	0	2	6	4	12	24	0	2	6	4	12	24	0	3	9	0	14.5	26.5	104.17%	110.42%
Oncology	3	1	3	4	5	16	3	1	6	4	12	26	3	2	7	0	12	24	111.54%	92.31%
Ophthalmology	1	1	0	0	6	8	1	1	0	0	7	9	1	1	0	0	7	9	111.11%	100.00%
Oral & Maxillofacial Surgery	0	4	10	0	2	16	0	4	10	0	6	20	0	4	10	0	6	20	100.00%	100.00%
Paediatric Neonatal Medicine	0	0	7	0	7	14	0	0	0	0	14	14	0	0	0	0	13.59	13.59	85.71%	97.07%
Paediatric Surgery	0	0	2	0	0	2	0	0	2	0	4	6	0	0	1	0	4	5	66.67%	83.33%
Palliative Care	0	0	0	2	0	2	0	0	0	2	0	2	0	0	2	0	0	2	100.00%	100.00%
Plastic Surgery	0	0	3	0	5	8	0	0	4	0	7	11	0	1	3	0	9	13	90.91%	118.18%
Paediatrics	3	4	9	2	9	27	4	4	9	2	9	28	2	4	4	0	9.56	19.56	78.57%	69.86%
Radiology	0	1	0	0	24	25	0	1	0	0	24	25	0	1	9.8	0	15.11	25.91	100.00%	103.64%
Renal Medicine	2	1	2	0	5	10	2	1	2	0	5	10	2	1	3	0	5	11	100.00%	110.00%
Respiratory Medicine	6	2	2	2	8	20	6	2	2	2	8	20	6	1	4	0	9	20	110.00%	100.00%
Rheumatology	0	0	1	2	3	6	0	0	1	2	6	9	0	1	2	0	6	9	83.33%	100.00%
Stroke Medicine	0	0	0	0	1	1	0	0	0	0	1	1	0	0	0	0	0	0	0.00%	0.00%
Trauma & Orthopaedics	0	4	3	1	9	17	0	11	4	1	14	30	0	11	4	1	14	30	93.10%	100.00%
Urology	1	3	2	0	3	9	1	3	3	0	5	12	1	3	3	0	6.6	13.6	90.91%	113.33%
Vascular Surgery	5	0	1	0	3	9	5	0	2	0	6	13	6.6	0	2	0	4.8	13.4	108.33%	103.08%
TOTAL	70	88	113	83	208	562	**71**	**93**	**125**	**83**	**272**	**690**	**65.47**	**94.6**	**132.45**	**76.4**	**300.49**	**669.41**	**93.40%**	**97.02%**

Increased vacancies since last report	
Decreased vacancies since last report	
No change in vacancies since last report	

Combining the information about trainees (on the 2016 TCS) with the locally employed doctors (Trust doctors – not on the 2016 TCS) allows a much better picture of the effect of vacancies on the rotas overall. Most rotas are staffed with a mixture of Trust doctors and trainees, so concentrating on one group only gave a misleading picture of the difficulties some departments are having on filling their rotas and running the departments.

Summary of the rota gaps:

- F1 establishment has increased due to supernumerary LTFT F1's.
- GPST1 have increased due to innovative GP posts.
- There is an increase in the number of Infectious Diseases posts due to the second wave of COVID.
- There are more LIFT F2 posts this quarter. These are temporary funded posts, LIFT trainees experience 2 sessions per week in general practice throughout their two year training programme. This runs alongside 4 days each week in hospital placements. However, not all LIFT F2's contribute to the rota.

The gaps in rota that was an area of concern particularly in some specialties have improved significantly since the introduction of the 2016 T&Cs and creation of the Guardian of Safe Working role. This is probably due in part to the continued relaxation in visa rules and addition of Medical & Dental Staff to the UKVI Shortage Occupation List.

Hull University Teaching Hospitals NHS Trust
Report for the Hull University Teaching Hospitals NHS Trust Board

Title:	**Report of Mortality data and deep dive patient level review of the Covid-19 Pandemic from the perspective of the Trust**
Responsible Director:	Dr Makani Purva, Chief Medical Officer
Author:	Mr Daniel Carradice, Consultant Vascular and Endovascular Surgeon and Associate Chief Medical Officer

Purpose of the report:	Present the key findings of mortality review at community, trust and patient level. Recommendations are made based upon the lessons learned locally, national guidance and best practical evidence.	
Strategic Goals:	Honest, caring and accountable culture	X
	Valued, skilled and sufficient staff	
	High quality care	X
	Great local services	
	Great specialist services	
	Partnership and integrated services	
	Financial sustainability	
Summary Key of Issues:	Safer care is at the heart of the Trusts' strategy and there must be a relentless drive to improve care and outcomes now more than ever. Key questions to consider are: Are we offering patients with Covid-19 the best possible survival? Are we minimising risk of Covid to patients with non-Covid disease? Findings: • There has been an increase in mortality due to the pandemic, this is reflected in both the hospital and community figures. • Surge 2 has been more significant than Surge 1. • Mortality rates compare well with national figures and are improving with time. • There is a national problem with hospital acquired Covid-19 infection, and local rates are in line with this also. • Detailed patient level reviews, national guidelines and best available evidence have identified themes of potential improvement in the quality of care and outcomes. • A detailed list of recommendations has been produced covering these 5 themes.	
Recommendations	1. Continue to redesign clear red, amber and green pathways, with the necessary environment for effective containment of the virus. 2. Develop measures to improve early recognition and diagnosis of COVID-19 and early identification of asymptomatic infection. 3. Regular asymptomatic testing for entire workforce in clinical environments, improved PPE guidance and prioritisation of staff vaccination. 4. Expansion of Infection Control Team and review of data intelligence management to support this and Mortality Teams. 5. Urgent priority vaccination targeted at patient groups likely to be high risk inpatients in the present or near future (E.g. P2 or P3 vascular and cardiovascular surgical patients.)	

Hull University Teaching Hospitals NHS Trust

Report of Mortality data and deep dive patient level review of the Covid-19 Pandemic from the perspective of Hull University Teaching Hospitals NHS Trust

1. PURPOSE OF THE REPORT

This report presents the available data regarding the mortality associated with the Covid-19 pandemic. It also presents a summary of the findings of in-depth patient level and outbreak level investigations by the Infection Control Team and the Medical Examiners. This analysis intends to draw out the key messages and learning points from the pandemic to date, in order to inform recommendations to improve future outcomes.

2. INTRODUCTION

The Covid-19 Global pandemic is the greatest challenge faced by the NHS and global healthcare systems (and societies) in living memory. The SARS CoV-2 virus is highly infectious and in some patient groups carries a mortality in excess of 40%. At times during the pandemic the local population have seen the highest rates of SARS CoV-2 infection in the country.

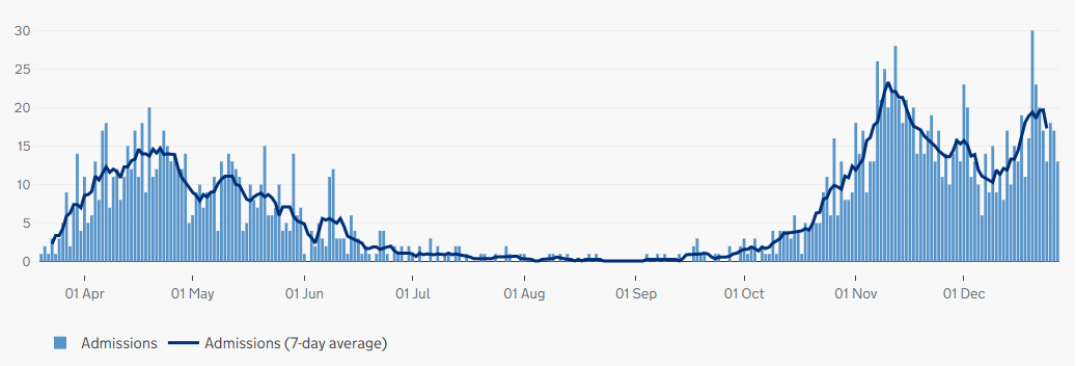
Safer care is at the heart of Hull University Teaching Hospital NHS Trusts strategy and quality improvement plan and there must be a relentless drive to improve care and outcomes now more than ever. The key questions for us to consider are: Are we offering patients with Covid-19 the best possible chance of survival? And are we minimising the risk to patients with non-Covid-19 disease?

3. LOCAL HEALTHCARE SYSTEM LEVEL DATA ANALYSIS

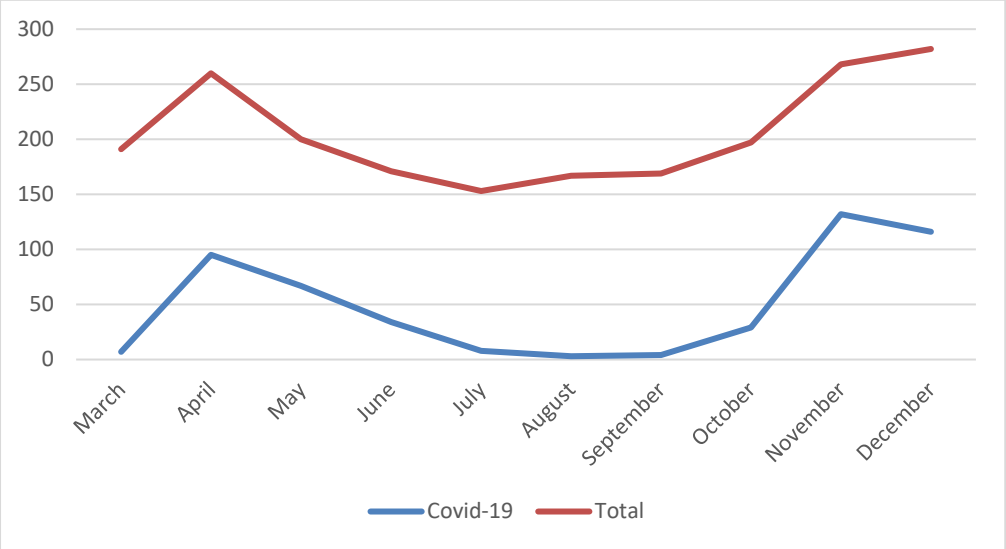
Key Findings of the HUTH Covid 19 Mortality report Jan 2020

See full report for further details.

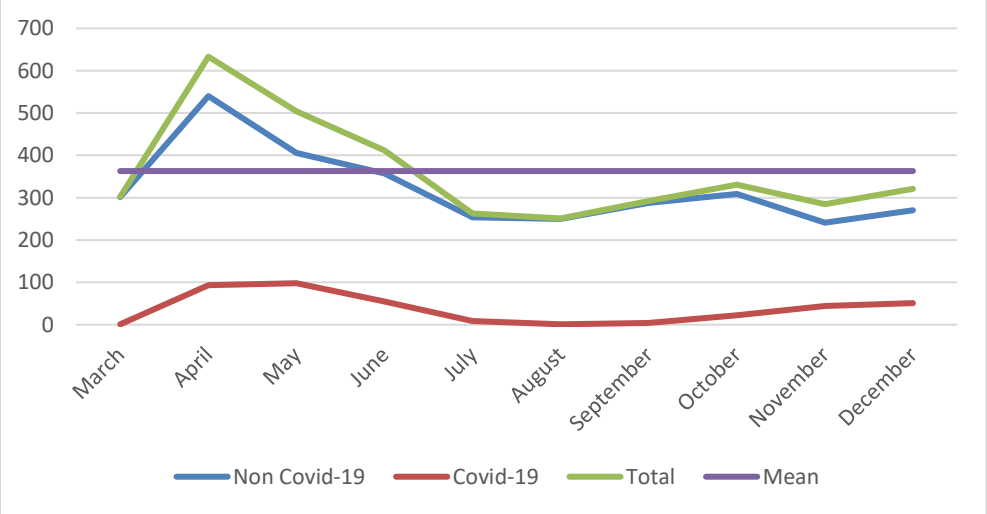
Daily numbers of COVID-19 patients admitted to Hull University Teaching Hospitals NHS Trust



Inpatient deaths March to December 2020



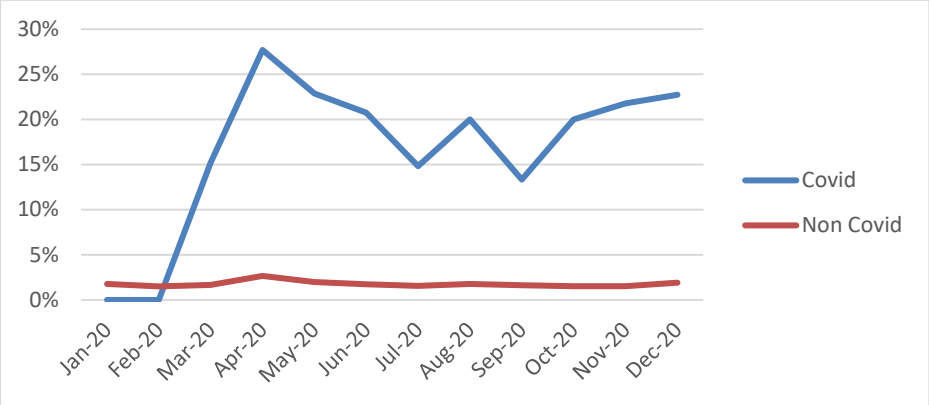
The number of deaths in the community by positive SARS CoV-2 test

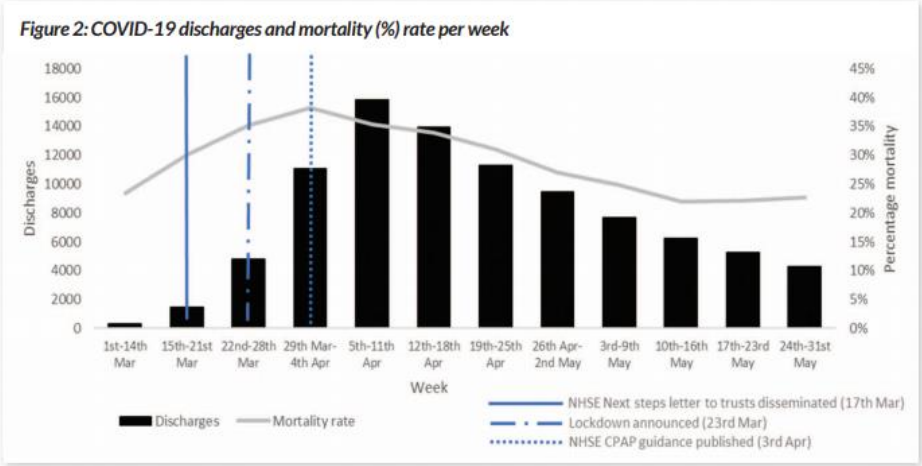


The pandemic locally can be split into 3 phases. Surge 1 (April, May and June), a latent phase and Surge 2 (October to present). Surge 2 to date has been associated with greater numbers of admissions, inpatients (ward and Intensive Care Unit (ICU)) and deaths.

There has been an increase in mortality in the population but it is unclear at present how large the excess is and to what extent it is related directly to Covid-19 disease or indirectly for example due to patients being reluctant to seek healthcare, or healthcare services being unavailable to non Covid - 19 disease.

Mortality rates for patients testing positive and negative for SARS CoV-2 on admission





(Source GIRFT Clinical practice guide for improving the management of adult COVID-19 patients in secondary care).

The mortality rates of those with SARS CoV-2 infection in the trust compare favourably with the national data and are also decreasing with time.

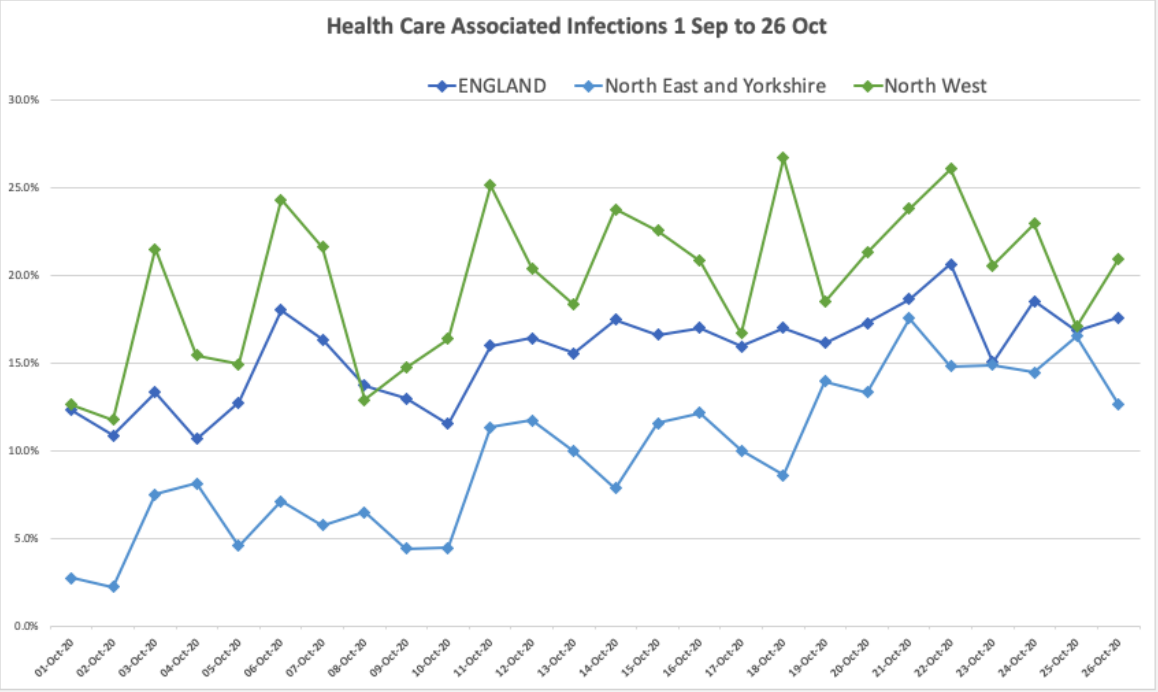
Patient factors including age, gender and other medical conditions are also similar to national figures.

Summary points:

- There has been an increase in mortality due to the pandemic, this is reflected in both the hospital and community.
- Surge 2 has been more significant than Surge 1.
- Mortality rates compare well with national figures and are improving with time.

4. PATIENT LEVEL DATA ANALYSIS

Key Findings of the HUTH Covid 19 Infection control and Medical Examiners report Jan 2020



(Source NHSE)

One of the greatest current threats to patient safety is hospital acquired SARS CoV-2 infection. 17.6% of infections in England are probable or definite healthcare associated infections, with some of the worst results seen in the North of the country. In HUTH over the pandemic 15.6% of cases in hospital have been defined as probable or definite hospital acquired cases. It is possible that as many as 78 deaths could be in part attributable to hospital acquired infection. Whilst these results are consistent with the national figures, it is critically important that progress is rapidly made so that future outcomes are better, especially as newer stains of the virus have a greater transmissibility.

In order to address this and identify other key themes as well as form recommendations aiming to improve future performance, a clinical group formed with representation from Infection control, Infectious diseases, Elderly medicine and the Medical Examiners of death. A detailed account of the findings and detailed specific recommendations can be found in their full report.

Theme 1: Patient pathways and clinical environment

The number 1 potentially reversible factor in hospital acquired infection and mortality was found to be the patient pathways and limitations the environment in which those patients were care for.

Recommendations 1: Patient pathways need to continue to be redesigned, with clinical input, to improve red, amber and green Covid streams and the necessary isolation and environment they require to minimise cross infection of patients.

Theme 2: Diagnosis and testing

Correct diagnosis of patients who are either asymptomatic or presenting with atypical symptoms is difficult. There have been and still are issues with obtaining tests and retests for both patients.

Recommendations 2: Solutions for this theme include staff educational programmes, IT flagging of abnormal results which may be consistent with infection and regular asymptomatic testing for patients on admission, day 3, day 5-7 and then at least weekly testing thereafter.

Theme 3: Workforce

Staff infections are also linked directly with hospital outbreaks and are often asymptomatic. There are challenges with Personal Protective Equipment (PPE) use which are linked in some cases to a lack of clarity regarding individual patient pathways.

Recommendations 3: Regular asymptomatic testing of all staff in clinical areas should be used, Infection control are to improve PPE guidance materials and improvements in pathways will also support this. All clinical staff should be vaccinated as a priority as soon as possible.

Theme 4: Infection Control

The resources of the infection control team have been stretched by the pandemic and would benefit from more real time data and IT support for maximum effectiveness for both this and the mortality review teams.

Recommendations 4: The Infection Control team needs to expand and there needs to be a review of data collection, analysis, flagging and reporting to both infection control and mortality teams.

Theme 5: Vaccination

Clearly ensuring a high rate of vaccine immunity is the route to control the pandemic, but this will take time. Reducing susceptibility in the vulnerable inpatient setting is a priority to prevent future hospital acquired infection and the risks this holds.

Recommendations 5: Vaccination needs to be targeted at patient groups who are likely to be inpatients in the present or near future. Surgical patients prioritised as P2 or P3 (especially those in vulnerable groups including but not limited to those awaiting vascular and cardiovascular procedures) should be prioritised as a matter of urgency.

Summary points

- There is a national problem with hospital acquired Covid-19 infection, and local rates are in line with this also.
- Detailed patient level reviews, national guidelines and best available evidence have identified themes of potential improvement in the quality of care and outcomes.
- A detailed list of recommendations has been produced covering these 5 themes.

Author Mr Dan Carradice

Job Title Consultant Vascular and Endovascular Surgeon and associate Chief Medical Officer

Date 7/1/2021

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Dr Tom Mace, Consultant Physician in Elderly Care

Dr Celestine Eshiwe, STR in Infection

Greta Johnson, Lead IPCN and DIPC

Dr Simon Stapley, Physician in Elderly Care

Dr Sharon Fan, Clinical Leadership Fellow and ME

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
TRUST BOARD
January 2021

Title:	**CLINICAL NEGLIGENCE SCHEME FOR TRUSTS – MATERNITY INCENTIVE SCHEME – YEAR THREE**
Responsible Director:	Beverley Geary - Executive Chief Nurse
Author:	Beverley Geary, Executive Chief Nurse Lorraine Cooper, Head of Midwifery

Purpose	The purpose of this report is to provide information in relation to the self-assessment against the ten safety actions, following impact of the Covid-19 pandemic.	
BAF Risk	BAF Risk 3: There Is a risk that the Trust is not able to make progress in continuously improving the quality of patient care	
Strategic Goals	Honest, caring and accountable culture	Y
	Valued, skilled and sufficient staff	Y
	High quality care	Y
	Great local services	Y
	Great specialist services	Y
	Partnership and integrated services	Y
	Financial sustainability	Y
Key Summary of Issues	The service has undertaken a review of the ten maternity safety actions to inform the Board of the impact of the Covid-19 pandemic. The reporting requirements to be able to successfully submit evidence to NHSR within the required time frame yet to be agreed.	

Recommendation	The Trust Board is requested to: • Review the current position of compliance with the ten maternity safety actions, • Review the actions required to meet the safety actions • Decide if any further information and/or assurance are required.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
TRUST BOARD January 2021

CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST)
MATERNITY INCENTIVE SCHEME – YEAR THREE

1. PURPOSE OF THE REPORT

The purpose of this report is to provide information following a review of the impact of Covid-19, and readiness to apply for a 10% reduction in the Clinical Negligence Scheme for Trusts (CNST) Maternity premium in 2021/22.

This report presents the following:

- Background
- Covid-19 impact on reporting
- Review of the year three CNST safety actions

2. BACKGROUND

As part of its insurance against clinical negligence claims and litigation, the Trust pays an annual insurance premium under the Clinical Negligence Scheme for Trusts (CNST), administered by NHS Resolution. The Maternity CNST rebate in 2019 was £470k with a further £21k allocation from Trusts who were not compliant with all ten safety actions.

3. COVID-19 IMPACT ON REPORTING

The 10 maternity safety actions are, as follows:

1. Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?
2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
3. Can you demonstrate that you have transitional care (TC) services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme? (ATAIN)
4. Can you demonstrate an effective system of clinical workforce planning to the required standard?
5. Can you demonstrate an effective system of midwifery workforce planning to the required standard?
6. Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2 (SBLCBv2)?
7. Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
8. Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?
9. Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?
10. Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification (NHSEN) scheme?

Pause in reporting procedure regarding the maternity incentive scheme

March 2020 NHSR contacted all Trusts to inform that in recognition of the current pressure on the NHS and maternity services, the majority of reporting requirements relating to demonstrating achievement of the maternity incentive scheme 10 safety actions would be paused with immediate effect until Monday 31 August 2020. Trusts were asked to continue to apply the principles of the 10 safety actions, given that the aim of the maternity incentive scheme is to support the delivery of safer maternity care.

There was still a requirement to report perinatal deaths to MBRRACE-UK and eligible cases to the Early Notification (EN) scheme. With a reasonable effort made to make a monthly Maternity Services Data Set submission to NHS Digital.
There was a requirement to comply with the following:

- Notification of all deaths;
- Complete the surveillance information for COVID-19 related perinatal deaths
- Complete the perinatal surveillance information for all other deaths, depending on capacity
- Complete the reviews using the Perinatal Mortality Review Tool, depending on capacity

In order to be eligible for payment under the scheme, trust must submit their completed Board declaration form to NHS Resolution by 12 noon on the 20 May 2020. The reporting period has once again been extended to the 15 July 2021. In response to the current situation, the 10% uplift to the Clinical Negligence Scheme for Trusts (CNST) for the maternity incentive scheme has not been collected for the year 2020/2021.

Safety Action	Compliance	Board Request
1	**Perinatal Mortality Review Tool COMPLIANT**	The PMRT group has been able to sustain reporting during the Covid-19 restrictions. The Trust Board will receive quarterly reports between September 2020 and September 2021. The report will evidence compliance with the required standards.
2	**PARTIAL COMPLIANCE**	Item 14 on the Maternity Record Standard has been removed from action two and will be progressed separately by NHSX. NHS Digital announced on 1 April 2020 that the Digital Maternity Record Standard (DMRS) compliance date had been delayed from Monday 30 November 2020 to Sunday 28 February 2021. The majority of the requirements for safety action two will be assessed on the trusts' MSDS submission for December 2020 made by 28 February 2021.
3	**PARTIAL COMPLIANCE**	Monthly audit of transitional care pathways has recommenced as these ceased in March, and further audit of avoidable admissions of term babies to Neonatal Unit to be undertaken for 20/21
4	**PARTIAL COMPLIANCE**	**Obstetric medical workforce** The review of the GMC national trainee survey to be completed and presented to the Trust Board in February 2021. **Anaesthetic medical workforce** Review of the action plan agreed by the trust Board in 2019, to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.7.2.5, 1.7.2.1 and 1.7.2.6 **Neonatal medical workforce** Formal recording in trust Board minutes that the neonatal unit meets the British Association of Perinatal Medicine BAPM national standards of junior medical staffing **Neonatal nursing workforce** Action plan in place agreed at trust Board level to meet the recommendations of the service specifications for neonatal nursing standards.
5	**PARTIAL COMPLIANCE**	Bi Annual Chief Nurse staffing report to Trust Board outlining: • Birthrate Plus® outcomes • Planned versus actual staffing levels • Midwife : Birth ratio • Compliance with supernumerary status and 1:1 care in labour • Actions to demonstrate progress with Birthrate Plus® recommendations
6	**NOT COMPLIANT**	During the covid-19 pandemic it has been difficult to implement some element of Saving Babies Lives Care Bundle V2, and in particular element one as carbon monoxide testing of women was suspended which has recommenced in November. Restrictions on the provision of the Growth Assessment Protocol for scanning will also impact on the ability to report accurately. The service is not currently compliant with Uterine Artery Doppler scanning as recommended in the Saving Babies Lives Care Bundle V2 – Appendix-D. The maternity service is working with ultrasonography and clinical support on a case of need to increase scanning capacity, delivery of training, increased physical space, procurement of capital equipment and recruitment of staff.

7	**COMPLIANT**	Although face to face patient involvement has been suspended the Maternity Voices Partnership is active and has completed an online survey of women across the LMS – Lockdown Babies. The report is available to the Trust Board via the Head of Midwifery
8	**PARTIAL COMPLIANCE**	Multi-professional training has not been possible during the emergency response due to Covid-19. Training in this unit restarted in June 2020 however the restrictions still affected our ability to provide full face-to-face, or 'hands on skills drills' training. The service has developed a package of multidisciplinary training provided as a half-day virtual/on-line training package as an alternative. With a number of skills drills at the start of the pandemic preparations in key areas such as theatres and labour ward. All clinical groups are on board with this and we are monitoring attendance.
9	**PARTIAL COMPLIANCE**	Safety Champion meetings were suspended but have now recommenced with dates for Chief Nurse to be agreed.
10	**PARTIAL COMPLIANCE**	Trust Board sight of Trust legal services and maternity clinical governance records of qualifying Early Notification incidents and number reported to NHS Resolution

7. SUMMARY

In summary, following a review of the current position the service is declaring partial compliance with seven of the required CNST Incentive safety actions, full compliance with two and non-compliance with one standard. An update will be provided quarterly, and the final evidence to be signed off by the Chief Executive will be submitted by 12 noon on Thursday 15 July 2021.

8. RECOMMENDATIONS

The Trust Board is requested to:

- Agree that the review of the position at this current time demonstrates partial achievement of seven of the maternity safety actions, non-compliance with one safety action, and two that meet the required standards
- Decide if any further information and/or assurance is required.

Lorraine Cooper
Head of Midwifery

Beverley Geary
Executive Chief Nurse

January 2021

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

MATERNITY SERVICES
FAMILY AND WOMEN'S HEALTH GROUP

Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 3 - Safety Action 1 – MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) Perinatal Mortality Review Tool

1. Purpose of the Report

The purpose of this report is to provide assurance to the Trust Board that the national Perinatal Review Tool is being completed by a multidisciplinary team, to the standard required by the Clinical Negligence Scheme for Trusts (CNST).

2. Introduction

MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) is a national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths.

NHS Resolution is operating a third year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. Trusts involved in the maternity incentive scheme will contribute an additional 10% of the CNST maternity premium creating the CNST maternity incentive fund. The scheme incentivises 10 safety actions Trusts demonstrating they have achieved all ten of the safety actions will recover their contribution and will also receive a share of any unallocated funds. In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution by 12 noon Thursday 20 May 2021. Trust submissions will be subject to a range of external verification points including cross checking with: MBRRACE-UK data (safety action 1 point a, b, c).

3. Requirements for Safety Action 1 Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard? **Appendix 1 and 2**

a)

i. All perinatal deaths eligible to be notified to MBRRACE-UK from Thursday 1 October 2020 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within four months of the death.

ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Friday 20 December 2019 to Wednesday 30 September 2020 will have been started by Thursday 31 December 2020. This includes deaths after home births where your Trust staff and the baby provided care died.

iii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Thursday 1 October 2020 will have been started within four months of each death. This includes deaths after home births where your Trust staff and the baby provided care died.

b)

i. At least 75% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Friday 20 December 2019 to Friday 31 July 2020 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least the tool has generated a PMRT draft report by Thursday 31 December 2020.

ii. At least 40% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Saturday 1 August 2020 to Thursday 31 December 2020 will have been reviewed using the PMRT, by a multidisciplinary review

team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool.

c) For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion.

d) Quarterly reports will have been submitted to the Trust Board from Thursday 1 October 2020 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety champion.

4. Perinatal Mortality Review Tool (PMRT)

The aim of the PMRT programme is to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales.

The PMRT has been designed with the following principles:

- A comprehensive and robust review of all perinatal deaths from 22+0 days gestation until 28 days after birth
- Reviews conducted using a standardised nationally accepted tool, ideally web-based, that includes a system for grading quality of care linked to outcomes
- Review by a multidisciplinary group at a meeting where time is set aside for doing the work;
- Parental input into the process from the beginning.
- An action plan should be generated from each review, implemented and monitored;
- The review should result in a written report, which should be shared with families in a sensitive and timely manner.
- Reporting to the Trust/Health Board executive should occur regularly and result in organisational learning and service improvements.
- Findings from local reviews should feed up regionally and nationally to allow benchmarking and publication of results, and thereby ensure national learning.

5. Summary

a) i. All perinatal deaths in the Trust from 1st October have been notified to MBRRACE-UK within 7 working days.
ii. 100% of deaths of babies born between 20 December 2019 and September 2020, suitable for the review using the PMRT tool have been commenced
iii. 100% of deaths of babies born from 1 October have been commenced

b) i. 80% of all babies deaths in the Trust who were born and died in the Trust, from Friday 20 December 2019 to Friday 31 July 2020 have been reviewed using the PMRT, by a multidisciplinary review team. Each review has been completed to the point that at least the tool has generated a PMRT draft report by Thursday 31 December 2020.

ii. 86% of all deaths of babies (suitable for review using the PMRT) who were born and died in the Trust, from Saturday 1 August 2020 to Thursday 31 December 2020 have been reviewed using the PMRT, by a multidisciplinary review team. Each review has been completed to the point that at least the tool has generated a PMRT draft report.

c) 90% of families were informed that a review of their baby's death has taken place. It was not possible to contact one of the families as they immediately returned to their

country of origin and had no further contact with the Trust. A robust system to ensure all families are informed has been introduced.

d) Quarterly reports to be submitted as per standard

6. **Recommendations**

The Trust Board is requested to:

- Receive the report outlining the details of the deaths reviewed and the action plans.
- Receive assurance by the team that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and have been met and an plan has been introduced to ensure standard c) is achieved
- Decide if any further information and/or assurance are required

Lorraine Cooper

Head of Midwifery January 21

APPENDIX 2
HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
PMRT ACTION TRACKER DEC 2020

Case	ACTIONS	Lead	Due date	R
67316	Individual reflection with the staff providing intrapartum care with regard to issues identified with risk assessment, escalation and CTG interpretation. Individual reflection with regard to the predicted presence of the neonatal team being required	AR	31/08/20	
67900	Smoking cessation training for all midwives on mandatory training	CC	31/12/20	
	Feedback to all midwives to emphasise the importance of ensuring all women receive written information with regard to fetal movements	JG	31/07/20	
	To look at the evidence and ensure a local guideline is agreed on the process for monitoring fetal growth when the women has significant weight gain in pregnancy	KS	31/08/20	
68178	Individual reflection with the practitioners involved with regard to pregnancy induced hypertension	LC	31/07/20	
	Individual reflection with the practitioners involved undertaking a CTG prior to IOL			
	Individual reflection with the practitioners involved with making plans for delivery	KS	31/07/20	
68754	The Latent phase guidance to be reviewed	JG	30/10/20	
	Individual feedback and training needs to be identified with midwives from the continuity of care team	JM	30/10/20	
	Review partogram document	SG	30/10/20	
	Individual feedback to midwives re completion of partogram	SC	30/10/20	
68890	Scans to be reviewed by senior consultant radiographer	KS	30/09/20	
	Individual feedback to the midwife providing intrapartum care re observations	LC	30/10/20	
	Individual feedback to the midwife with regard to postnatal investigations following a loss	LC	30/10/20	
	Introduce a robust process for informing parents with regard to the PMRT and obtaining feedback	SC	01/09/20	
69457	AN appointments and scans reduced due to COVID pandemic - review plan to ensure adequate surveillance	KS	28/02/21	
	Review guideline for Diabetes in pregnancy			
70106	Individual feedback with reference to CTG interpretation	JC	28/02/21	
	Development of a neonatal checklist	AM	31/01/21	
70248	Bereavement Pathway guideline and checklist under review & to be updated	AM	31/01/21	
	To be incorporated in to Neonatal Nurse Education	AM	31/03/21	
70272	Feedback to be given to the midwife who completed the booking	JM	28/02/21	
	Reflection to be undertaken with the Obstetric Bereavement Lead	KS	28/02/21	
	Feedback to midwives providing care on the Labour Ward	AR	28/02/21	
71128	CO monitoring suspended due to COVID – still offer smoking cessation services. Feedback to community M/W's	JM	28/02/21	

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
TRUST BOARD January 2021

Midwifery Staffing update January 2021 in Line with Birthrate Plus® (BR+)

Birthrate Plus® (BR+) is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings, and have been endorsed by the RCM and RCOG.

The RCM strongly recommends using Birthrate Plus® (BR+) to undertake a systematic assessment of workforce requirements, since BR+ is the only recognised national tool for calculating midwifery staffing levels.

Hull University Teaching Hospital maternity services undertook the Birthrate Plus® In June 2018 a recognised tool based upon an understanding of the total midwifery time required to care for women.

The report identified that the maternity service required 187.18WTE midwives to provide midwifery care. The current midwifery establishment is 180.3WTE and the staffing report for midwifery proposed a role for B3 Maternity Support Workers to support midwifery staffing in community and postnatal ward settings. Currently the service in collaboration with the Local Maternity System [LMS] is working on plans to develop this role and to ensure a robust training and education package is in place with support from local colleges.

The BR+ Intrapartum acuity tool was implemented in June 2019, a score system based upon indicators of normality in the progress and outcome of labour and the health of the baby at birth, together with other indicators which identify changes from normality. The score sheet provides a research-based method to enable the midwife to assess the midwifery workload required to care for a woman at any time in the intrapartum and immediate post delivery period, based on a minimum standard of one to one care for all women in labour.

The Acuity Tool indicates any red flag incidents and complements the Maternity Staffing and Escalation policy.

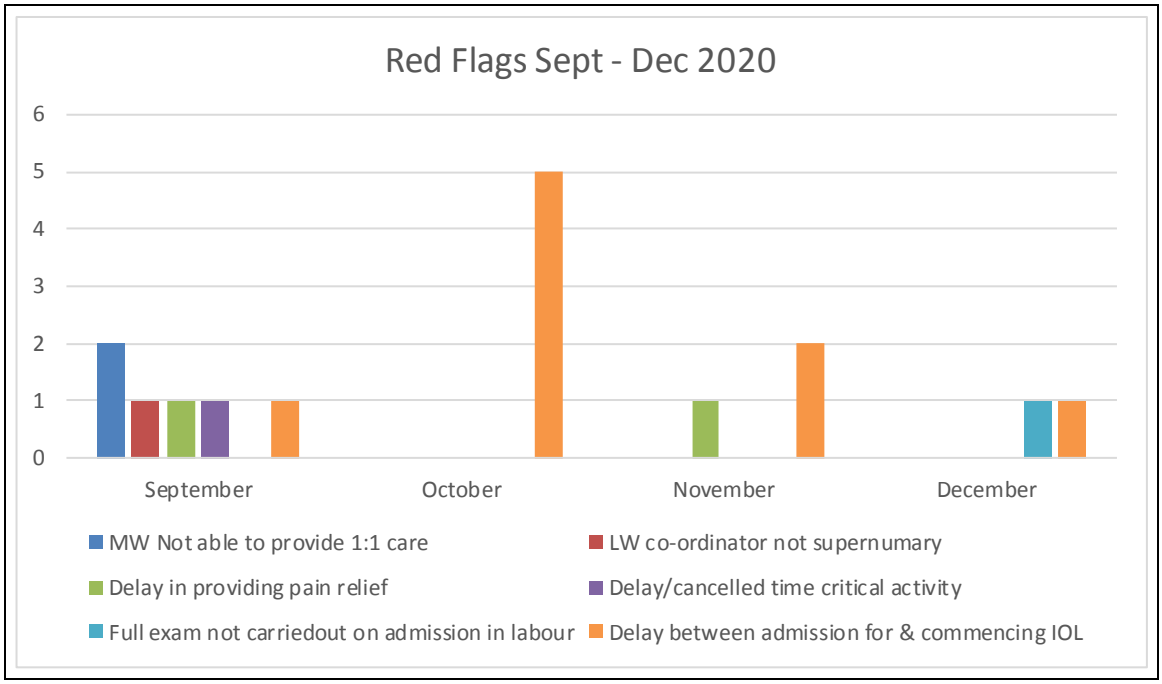
The red flags for maternity services are:

- Delayed or cancelled time critical activity.
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of two hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

The Birth Rate plus Acuity Tool has identified 15 red flag incidents from 01/09/2020 – 23/12/2020

September (5)
October (5)
November (3)
December (2)

The tool has identified one episode when 1:1 care in labour was not achieved; this was for a short time period and due to high acuity/complexity of women on the labour ward.



Lorraine Cooper
Head of Midwifery
January 2021

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
TRUST BOARD January 2021

Benchmark – MBRRACE-UK Perinatal Mortality Surveillance Report 2020

MBRRACE-UK is commissioned by the Healthcare Quality Improvement Partnership (HQIP) to undertake the Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI-CORP). The recent MBRRACE report focuses on the surveillance of perinatal deaths from 22+0 weeks gestational age (including late fetal losses, stillbirths, and neonatal deaths) of babies born between 1st January and 31st December 2018.

Definitions:

- Late fetal losses: a baby delivered between 22+0 and 23+6 weeks gestational age showing no signs of life, irrespective of when the death occurred;
- Stillbirths: a baby delivered at or after 24+0 weeks gestational age showing no signs of life, irrespective of when the death occurred;
- Neonatal deaths: a live born baby (born at 20+0 weeks gestational age or later) who died before 28completed days after birth.

Perinatal mortality surveillance involves the identification and notification of all eligible deaths and the timely collection of a limited and tightly defined demographic and clinical dataset. This report is published in 2020 – a year dominated by the COVID-19 pandemic. We do not yet know how its impact on maternity and neonatal services has affected the outcomes for families and babies. The continued downward trend in perinatal deaths across the four nations of the UK is a reflection and the impact of a range of national initiatives to address safety in maternity and neonatal care. The recent report identified overall 25 key findings of which four are highlighted within the report.

Key Findings:

- Perinatal mortality has reduced by 15% over five years, from 6.04 per 1,000 total births in 2013 to 5.13 per 1,000 total births in 2018, equivalent to approximately 670 fewer deaths in 2018.
- Over a third of this reduction has occurred since 2017: this increased trajectory is likely to have resulted from various national initiatives to reduce perinatal mortality across the UK.
- Stillbirth rates have reduced by just over 16% from 4.20 per 1,000 total births in 2013 to 3.51 per 1,000 total births in 2018, representing approximately 500 fewer stillbirths in 2018.
- Neonatal mortality has reduced by 11% from 1.84 per 1,000 live births in 2013 to 1.64 deaths per 1,000 live births in 2018, representing approximately 170 fewer neonatal deaths in 2018.

Inequalities in health remain a high priority and the connection between risk and poverty is also clear, with women living in the most deprived areas at an 80% higher risk of their baby dying. These disparities are stark and unacceptable, yet they have been known about for years.

Stillbirth rates by socio-economic deprivation quintile of residence by year: births in 2016 to 2018

Socio-economic deprivation quintile*	Number (%)§						Rate per 1,000 births§		
	Stillbirths						Stillbirths†		
	2016		2017		2018		2016	2017	2018
1 - Least deprived	456	(14.9)	424	(14.9)	387	(15.0)	2.96	2.81	2.61
2	546	(17.8)	471	(16.6)	400	(15.5)	3.48	3.12	2.77
3	608	(19.8)	545	(19.2)	504	(19.5)	3.95	3.58	3.41
4	671	(21.9)	660	(23.2)	596	(23.1)	4.33	4.34	4.09
5 - Most deprived	764	(24.9)	733	(25.8)	686	(26.6)	4.91	4.84	4.68
Not known	20	(0.7)	7	(0.2)	6	(0.2)	4.33	2.74	2.40

The report identified 10 recommendations for policy makers, Trust and Health Board Directors, commissioners, Heads of Midwifery, service planners and Health Professionals. Organisations were requested to benchmark current service provision against the following recommendations.

1. Develop public health initiatives to address issues linked to high risk populations.
2. 2. Ensure that healthcare providers have implemented national initiatives to reduce stillbirth and neonatal deaths and are monitoring their impact on reducing preterm birth.
3. 3. Ensure that there is a multi-agency targeted approach affecting women living in areas of high socioeconomic deprivation across all points of the reproductive, pregnancy and neonatal healthcare pathway.
4. Identify the specific needs of Black and Asian populations and ensure that these are addressed as part of their reproductive and pregnancy healthcare provision.
5. 5. Use the MBRRACE-UK real-time data monitoring tool as part of regular mortality meetings to help identify why an organisation's stabilised & adjusted stillbirth, neonatal mortality or extended perinatal mortality rate falls into the red or amber band.
6. Investigate potential modifiable factors in the treatment of neonates when an organisation's stabilised and adjusted neonatal mortality rate falls into the red or amber bands after exclusion of deaths due to congenital anomalies. Ensure that this encompasses both local population characteristics and quality of care provision.
7. 7. Explore local variation in post mortem uptake by different population groups, particularly by ethnicity and deprivation, and tailor training for consent takers based on the local population.
8. Undertake placental histology for all babies admitted to a neonatal unit, preferably by a specialist perinatal pathologist.
9. Notify all deaths via the MBRRACE-UK system within 7 working days of the death occurring, but with an aim to notify within 2 working days. Incorporate mechanisms for timely notification into local processes.
10. Aim for completion of all surveillance data within 90 days to enable timely review with the PMRT and effective use of the MBRRACE-UK real-time data monitoring tool. Utilise the real-time data monitoring tool to ensure the data entered is complete and of high quality.

The maternity and neonatal service has undertaken benchmarking to understand its current positions and establish the actions required to achieve the 10 recommendations set out in the report. HUTH are currently compliant with 5 of the 10 standards and have developed a plan to support the recommendations.

	Recommendations	Action Leads identified in the Report	Recommendation implemented? Yes/No	Action Plan	Action Lead	Timescale
Rec. 1	Develop public health initiatives to address issues linked to high risk populations.	Policy Makers, UK Public Health Services.	Yes			
Rec. 2	Ensure that healthcare providers have implemented national initiatives to reduce stillbirths and neonatal deaths and are monitoring their impact on reducing preterm birth	Service Commissioners, Trust and Health Board Directors, Clinical Directors.	No	A.. Participation in MatNeoSIP - Interventions to reduce maternal smoking & optimising care for Preterm Newborn undertaken & improvement documented (ongoing work & participation through LMS & PSN) B. Compliance with HSIB/ EBC investigations- lessons cascaded C. MBRRACE & PMRT - reviews and cascading lessons learnt. D. Full implementation of the SBLV2 Care Bundle	Sarah Green Bereavement Lead	31/05/2021
Rec. 3	Ensure that there is a multi-agency targeted approach for women living in areas of high socio-economic deprivation across all points of the reproductive, pregnancy and neonatal healthcare pathway.	Policy Makers, UK Public Health Services, Service Planners and Commissioners at local and national level.	No	**CURRENT PROVISION HUTH** A. 1.0 WTE B7 Midwife for Healthy lifestyle key role to reduced smoking and obesity rates/education/ training and education in maternity services B. 1.0 WTE B8A Continuity of Care Midwife key areas of improvement to increase the % of BAME population and those social deprivation that are placed onto a CoC pathway C. 1.0WTE B7 Vulnerabilities midwife Local maternity services to work collaboratively with both local commissioners to ensure a target approach for women living in areas of high socio-economic deprivation. **Key areas for improvement:** A. Increase the number of women placed onto a CoC pathway. B. Explore the development of maternity and neonatal MDT	Lorraine Cooper/Jaishree Hingorani	31/03/2021
Rec. 4	Identify the specific needs of Black and Asian populations and ensure that these are addressed as part of their reproductive and pregnancy healthcare provision.	Service Planners, Service Commissioners, Health Professionals.	No	Strength continuity of Carer (CoC) for the local population achieving the national ambition of 35% March 2021 (current positon HUTH 26%)	Jennifer Moverley CoC Lead	31/03/2021
Rec. 5	Use the MBRRACE-UK real-time data monitoring tool as part of regular mortality meetings to help identify why an organisation's stabilised and adjusted stillbirth, neonatal mortality or extended perinatal mortality rate falls into the red or amber band.	Trust and Health Board Directors, Clinical Directors, Heads Of Midwifery, Health Professionals.	Yes			
Rec. 6	Investigate potential modifiable factors in the treatment of neonates when an organisation's stabilised and adjusted neonatal mortality rate falls into the red or amber bands after exclusion of deaths due to congenital anomalies. Ensure that this encompasses both local population characteristics and quality of care provision.	Trust and Health Board Directors, Clinical Directors, Heads Of Midwifery.	Yes	Local & Network level; Active neonatal participation in ODN work streams to review and improve modifiable factors and variation in neonatal mortality.		
Rec. 7	Explore local variation in post mortem uptake by different population groups, particularly by ethnicity and deprivation, and tailor training for consent takers based on local population.	Trust and Health Board Directors, Clinical Directors, Heads Of Midwifery, Health Professionals.	No	**CURRENT PROVISION HUTH** HUTH has 2 bereavement midwives/2 obstetric consultants Recommendation 7 to be added to the mortality review ToR and Perinatal mortality review groups will review on a quarterly basis within the PMRT report.	Dr K. Sivakumar/Dr A. Manou	31/01/2021
Rec. 8	Undertake placental histology for all babies admitted to a neonatal unit, preferably by a specialist perinatal pathologist.	Trust And Health Board Directors, Clinical Directors, Heads Of Midwifery, Health Professionals.	No	To develop a clinical pathway to undertake placental histology for all babies admitted to the neonatal unit at HUTH	Angela Rymer/Jayne Gregory/Kate Lamming	31/03/2021
Rec. 9	Notify all deaths via the MBRRACE-UK system within 7 working days of the death occurring, but with an aim to notify within 2 working days. Incorporate mechanisms for timely notification into local processes.	Trust and Health Board Directors, Clinical Directors, Heads Of Midwifery, Health Professionals.	Yes	**CURRENT PROVISION HUTH** Current pathway in place to ensure notification within 7 days		
Rec. 10	Aim for completion of all surveillance data within 90 days to enable timely review with the PMRT and effective use of the MBRRACE-UK real-time data monitoring tool. Utilise the real-time data monitoring tool to ensure the data entered is complete and of high quality.	Trust and Health Board Directors, Clinical Directors, Heads Of Midwifery, Health Professionals.	yes	Local Pressure - Post mortem reports not always available within time frames - surveillance cannot be completed without cause of death known. No cases missed since implementation.		